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Codependency in Master's-Level Counseling Students

Terri Lynne Pardee
Andrews University

Andrews University

School of Education

CODEPENDENCY IN MASTER'S-LEVEL COUNSELING STUDENTS

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Terri Lynne Pardee

March 2007

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APPROVAL BY THE COMMITTEE:

Chair: Frederick A. Kosinski, Jr.

Member: Jimmy Kijai

Dean, School of Education
James R. Jeffrey

Member: Nancy J. Carbonell

External Examiner:

Date approved 3/28/07

ABSTRACT

CODEPENDENCY IN MASTER'S-LEVEL COUNSELING STUDENTS

by

Terri Lynne Pardee

Chair: Frederick A. Kosinski, Jr.

ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: CODEPENDENCY IN MASTER'S-LEVEL COUNSELING STUDENTS

Name of researcher: Terri Lynne Pardee

Name and degree of faculty chair: Frederick A. Kosinski, Jr., Ph.D.

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Purpose of the Study

The purpose of this study was to examine codependency in master's-level counseling students, to determine if there was a significant difference between incoming and exiting students, and to investigate codependency as related to age, gender, and religious preference.

Method

The Codependency Assessment Tool was administered to 275 Spring Arbor University master's-level counseling students to measure codependency in five core areas: Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Results

Respondents' CODAT mean score showed a minimal level of codependency. There were no significant differences between incoming and exiting students on the CODAT composite scores or on each of the core areas.

Scores were not significantly different for the composite or the core areas among different age groups. A significant interaction effect existed between student status and age on the composite score. Incoming students ages 22 to 27 scored significantly higher on the composite score than exiting students of the same age.

In the core area Low Self-Worth, exiting students ages 22 to 27 reported significantly more positive self-worth than students ages 28 to 34. Among students ages 22 to 27, exiting students reported higher self-worth than incoming students. There were no significant interaction effects between student status and age on the other core areas.

There was no significant difference between males and females on the composite score. On the core area Hiding Self, males were significantly more likely to hide their true selves than females. There were no significant interaction effects between student status and gender on the core areas.

There were no significant differences among the religious preferences with regard to the composite or the core area scores. There were no significant interaction effects between religious preference and student status on the core areas.

Conclusion

The self-report of respondents did not indicate that there were high levels of codependency present. However, students' composite scores did suggest that some codependent tendencies were present in a majority of the students. In considering

codependency, counselor education programs can assist students to identify and manage any limiting codependent tendencies.

I dedicate this effort to my mother
who taught me the value of education,
to my husband who taught me
the meaning of unconditional love,
and to my two sons, Spencer and Eli, who
taught me the importance of perspective.

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I thank Spring Arbor University's counseling students for their willingness to participate in this study and for their commitment to making a positive difference in their communities. I must also thank Greg Gallagher as well as the staff and clients of Recovery Technology who reinforced for me why our commitment to training well-equipped counseling students really matters.

I thank my mother, Jacqueline Abbott, and husband, William Pardee, for their never-ending support and confidence in me. A loving thanks to my sons Spencer and Eli Pardee who provided me the momentum to keep going.

Most importantly, I am grateful to my Heavenly Father who provides meaning and purpose for my life. To God be the glory.

CHAPTER I

INTRODUCTION

For the past 3 years I have worked as the program coordinator for Spring Arbor University's Master of Arts in Counseling program. The counseling program is relatively new and was first offered to students in Fall 2000. I began working with the counseling program during its second year. It became quickly evident to me that some students in this area of studies had unhealthy relational patterns as demonstrated by their interactions with faculty, staff, and peers. Unfortunately, students admitted into the counseling program the first year were merely screened for academic ability and were not involved in any type of interview process to determine "goodness of fit" to the counseling profession. This oversight to assess personal characteristics and relational patterns proved problematic in terms of class dynamics and internship experiences.

As a result, an interview was added to the admissions process. During the interview, applicants were screened based on personal characteristics that would equip them to be successful as professional counselors. In the past 3 years, I interviewed approximately 500 counseling applicants. One revealing question asked the applicants to discuss what was motivating them to pursue a degree in counseling. Answers included "being called by God," "wanting to make a difference in the world," "being gifted at giving others advice," and "needing to be needed by others." As applicants detailed their

answers, it appeared that some saw the profession of counseling as a possible way to have their own needs met.

Today more accountability is being placed on counselor education programs to endorse only those students who have both the personal and professional qualities necessary to be ethical and competent practitioners. Keeping this ethical standard in mind, I began to struggle with how to better identify, understand, and provide intervention for students who entered into the counseling field who might otherwise get their relational needs met at the client's expense. It is this internal struggle that has prompted me to explore whether a codependent style of relating is prevalent in students desiring to earn a degree in counseling. Additionally, the level of codependency in students entering the program was compared to that of students exiting the program to assess what impact the existing curriculum had on students' level of codependency.

Rationale

Individuals pursue a career in counseling for many different reasons. Some people view counseling as a rewarding career that would allow them to help others and make a difference in people's lives. Other individuals believe it would be exciting to help clients gain self-understanding as they make the transition from being victims to seizing control of their lives (Corey & Corey, 2003). Perhaps central to the appeal of a career in counseling is its relational core. The therapeutic relationship serves as the context in which client growth occurs (Trembley, 1996).

Some clinicians believed that the therapeutic relationship plays a more prominent role in clients' positive changes than any other specific theoretical approach or technique (Glauser & Bozarth, 2001). For example, many clients who seek counseling are

experiencing interpersonal difficulties. Through the safety of the therapeutic relationship, clients are free to explore unresolved issues and have an interpersonal corrective experience, learning healthier patterns of relating (Trembley, 1996). The therapeutic relationship is also rewarding for the therapist. Therapists have the potential for growth from working with clients just as clients benefit from working with the therapist (Kottler, 1993).

John Holland's typology approach to career choice (1997) considered individuals' career preference to be an extension of their personalities. People are drawn to careers that are aligned with their interests and that allow for need fulfillment. Holland believed careers could be grouped into six categories: realistic, investigative, artistic, social, enterprising, and conventional. Counseling falls under the social personality type that represents individuals who are typically sociable, nurturing, cheerful, responsible, conservative, achieving, and self-accepting. Corey and Corey (2003) identified a number of factors that potentially motivate individuals to pursue a career in counseling. Motivators included various needs such as the need to make an impact, to return a favor, to care for others, to seek self-help, to be needed, to increase prestige, to provide answers, and to be in control. These authors further mentioned that while all individuals have needs, it is important that counselors be aware of their own personal needs so they can seek appropriate ways to get their needs met.

Counselors who remain unaware of their own personal needs may seek need fulfillment through their interactions with clients (Corey & Corey, 2003). A codependent counselor may attempt to control the feelings, actions, and thoughts of clients through manipulation and compulsive advice-giving. These counselors may have an exaggerated

need to be needed, which fosters client dependency and helplessness. In addition, the codependent counselor may compromise the therapeutic process to gain client approval, to maintain the role of being an infallible expert, or to delay client termination in pursuit of a personal agenda.

A counselor who is dependent on the client for need fulfillment poses a dangerous threat to the integrity of the therapeutic relationship, especially since the client enters therapy with an inherent tendency to be dependent on the therapist (Corey, Corey, & Callanan, 2003). This mutual dependency, coupled with an unequal power distribution, exacerbates the development of a codependent relational pattern within the therapeutic relationship.

When a counselor's codependent relational patterns enter into the therapeutic relationship, clients are robbed of a corrective interpersonal experience. As a result the client may lose the opportunity to learn healthier patterns of relating and they may have a reinforced perception of being helpless.

Counselors who engage in codependent relational patterns with clients risk breeching ethical guidelines by attempting to meet their own personal needs within the therapeutic relationship. The American Counseling Association's *Code of Ethics and Standards of Practice* (2005) mandated that "counselors encourage client growth and development in ways that foster the interest and welfare of clients and promote the formation of healthy relationships" (p. 4).

Counselors interacting with clients from a codependent framework not only practice contrary to ethical guidelines of the American Counseling Association, but also violate Kitchener's (1984) moral principles that serve as a basis for ethical functioning.

These principles include beneficence, justice, fidelity, veracity, autonomy, and nonmaleficence. The last two principles, autonomy and nonmaleficence, are in direct opposition to a codependent style of relating. Autonomy is achieved in therapeutic relationships by allowing clients the freedom to make their own choices. Similarly, nonmaleficence in the counseling setting maintains that counselors not cause their clients any harm.

One of the fundamental responsibilities of counselor education programs is to prepare students to become competent and effective professionals who practice within ethical guidelines. This responsibility calls for training programs to go beyond monitoring students' academic achievement and skill progression to considering personal and relational characteristics (Lumadue & Duffey, 1999). Kottler (1993) suggested, "The force and spirit of who the therapist is as a human being most dramatically stimulates change. . . . It is not what the therapist does that is important – but rather who he is" (p. 3). Importance of the personal and relational characteristics of the counselor is further reinforced by the work of Glauser and Bozarth (2001), which indicated that one of the variables most related to success in counseling outcomes is the therapeutic relationship.

Counselor training programs need to recognize the threat that a counselor's codependent patterns pose to a functional therapeutic relationship. Beyond recognition, training programs may also formally address these dynamics in the curriculum by helping students increase awareness of their own unhealthy relational patterns, identify unmet needs, and explore appropriate means of personal need fulfillment beyond the therapeutic relationship. Individuals pursuing a career in counseling must address any unhealthy codependency patterns to be successful in this relational field.

It is also worth noting that there is a paucity of professional literature on the counselor-client codependency issue. This absence suggests that further investigation is warranted.

Statement of the Problem

Counselor training programs have an ethical responsibility to safeguard both the client's welfare and the counseling profession. Counseling programs are called upon to assess the prevalence of codependency in their students in order to make curricular changes that can help to prevent the counselor's codependency from entering into the therapeutic relationship. This investigation hoped to identify how many counseling students actually were codependent in their interactions with others.

Purpose of the Study

The purpose of this study was to explore the prevalence of codependent personality traits among master's-level counseling students, to determine if there was a significant difference between incoming and exiting students, and to investigate codependency as related to age, gender, and religious preference. These findings will help to determine whether curricular changes are needed in counselor education programs.

Theoretical Framework

The term *codependency* was originally coined to describe interpersonal dynamics between a chemically dependent person and his/her caretaker (Beattie, 1987). This definition has since been expanded to encompass any relationship in which there is a loss of self. In general, codependent individuals focus on what is happening with those around

them, are dependent on others for personal need fulfillment, try to control the lives of others, and lose touch with their own thoughts and feelings (Fischer & Crawford, 1992).

For the purposes of this investigation, the theoretical framework of the codependency construct was considered along five main dimensions that dominate the professional literature. First, codependent individuals typically focus on others to the point of self-neglect (Fischer & Crawford, 1992; Fuller & Warner, 2000; Granello & Beamish, 1998; O'Brien & Gaborit, 1992; Wright & Wright, 1999). This tendency may manifest itself as attempting to control others, taking responsibility for meeting the needs of others, and having enmeshed relationships with others.

Second, codependent individuals have a low sense of self-worth (O'Brien & Gaborit, 1992; Springer, Britt, & Schlenker, 1998). This low self-esteem often results from feelings of shame. These individuals attempt to gain their self-esteem through the approval of others or vicariously through the success of significant others. Attempts to increase self-worth are also sought through their willingness to "suffer" for the sake of others.

Third, codependent individuals have dysfunctional relational dynamics in their family of origin (Burris, 1999; Clark & Stoffel, 1992; Cowan, Bommersbach, & Curtis, 1995; Cullen & Carr, 1999; Fischer & Crawford, 1992; Prest & Protinsky, 1993). This dysfunction may include childhood abuse, enmeshment, authoritarian parenting styles, and non-nurturance. Children growing up in dysfunctional families learn to survive in their home environments by being overly sensitive to the needs of others. Frequently the parent-child roles are reversed so that the child is forced to demonstrate parentified

behaviors as they take care of needy parents. The child learns that fixing the problems of other people is a means of preserving one's self-worth.

Fourth, codependent individuals develop a false self that serves to hide the true self (Carson & Baker, 1994; Morgan, 1991). Since these individuals focus almost exclusively on the needs of others, their personal identity is unable to form. These individuals deny feelings and thoughts that pose a risk of rejection by significant others. A false self emerges that is compatible with the self that others will approve and accept. After prolonged hiding of the true self, an individual is rarely able to distinguish his/her real self from that of others.

Finally, codependent individuals are preoccupied with real or imagined medical problems (Fagan-Pryor & Haber, 1992; Gotham & Sher, 1996). As a result of neglecting personal needs, mismanaging anxiety surrounding relationships, experiencing associated feelings of shame and low self-worth, and hiding true self, these individuals tend to manifest their relational dysfunction as somatic complaints.

The Codependency Assessment Tool (CODAT), developed by Hughes-Hammer, Martsolf, and Zeller (1998b) is a 25-item multivariate tool designed to measure codependency along these five key areas identified in the professional literature. Hughes-Hammer et al. refer to these five key areas as core areas, which include Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Research Questions

Research Question 1: What is the level of codependency in master's-level counseling students?

Research Question 2: Is there a significant difference in level of codependency between incoming and exiting master's-level counseling students?

Research Question 3: Is codependency in master's-level counseling students related to age, gender, or religious preference?

Research Hypotheses

Research Hypothesis 1: There is a significant difference between incoming and exiting students on the CODAT composite score.

Research Hypothesis 2: There are significant differences between incoming and exiting students on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Research Hypothesis 3: There are significant interaction effects between student status and age on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Research Hypothesis 4: There are significant interaction effects between student status and gender on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Research Hypothesis 5: There are significant interaction effects between student status and religious preference on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Significance of the Study

While the professional literature explored many important aspects of the codependency construct, no investigations were found that assessed the level of

codependency in counseling students. Since one of the fundamental responsibilities of counselor education programs is to prepare students to become competent and effective professionals, it is important to determine the prevalence of codependency among counseling students. Based on these findings, counselor education programs will be better able to determine the extent to which codependent tendencies may exist among their students as well as if there is a need to develop applicant screening procedures and curricula to formally address these tendencies.

Delimitations

The delimitations of this study include the following:

1. This study was limited to master's-level counseling students enrolled full time at Spring Arbor University. Spring Arbor University is a private Free Methodist University with a main campus located in Spring Arbor, Michigan. The University has 10 sites in Michigan that offer the Master of Arts in Counseling (MAC) program. The program is offered on the main campus as well as nine other satellite sites that are located in Battle Creek, Kalamazoo, Grand Rapids, Lansing, Flint, Dearborn, Troy, Gaylord, and Lambertville.

Limitations

The limitations of this study include the following:

1. The survey was administered to students in their cohort groups. Due to the differences in scheduled orientation nights for the groups, it was possible for students who took the survey to discuss the experience with students who had not yet taken the survey.

2. The students enrolled at Spring Arbor University typically share a belief system in God or a higher power. This belief system and accompanying religious upbringing inherently heighten sensitivity and service to the needs of others.

3. The population surveyed is comprised of a group of individuals who typically are high achievers. A minimum of a 3.0 grade point average is required for admission into the graduate programs. It is yet to be determined if there is a significant relationship between codependency and level of academic achievement.

Assumptions

It is assumed that students responded to the items on the survey truthfully and to the best of their ability. It is possible, however, that students answered the questions in a way that either underestimated or overestimated their level of relational dysfunction.

Definition of Terms

Codependency is a pattern of relating in which individuals seek to control self and others, take responsibility for meeting other people's needs, and distort interpersonal boundaries. Individuals with codependency traits typically focus on others to the point of self-neglect, have low self-worth, hide their feelings, experience somatitization, and have issues with their family of origin.

Students are individuals who were enrolled full time (a minimum of six credit hours per semester) in Spring Arbor University's Master of Arts in Counseling program.

Incoming students are those students who entered the MAC program in the fall of 2005, who had not yet begun any graduate coursework related to the counseling field, and who voluntarily participated in the study.

Exiting students are those students who enrolled in the internship during the 2005-2006 school year and who voluntarily participated in the study. To be eligible for their internships, the students must complete all coursework in the core curriculum with a grade of "C" or higher and earn a minimum grade point average of 3.0.

Transfer students are those students who took counseling-related coursework at another institution. A student could transfer in up to 12 credits from an approved institution, providing he/she earned a grade of "B" or higher. Transfer students were not included in the incoming group; however, they may have qualified to participate with the exiting group.

Organization of the Study

This dissertation contains five chapters.

Chapter 1 includes the introduction, statement of the problem, purpose of the study, theoretical framework, research questions, research hypotheses, significance of the study, delimitations of the study, limitations of the study, assumptions, and definitions of terms.

Chapter 2 contains a review of the literature surrounding codependency. This review focuses on the definition, history, etiology, and characteristics of codependency. Consideration is also given to codependency as a personality style, and as a social construct. How codependency influences family dynamics is explored. Finally, opposition to the codependency construct as well as therapeutic considerations are reviewed.

Chapter 3 describes the population, intervention, instrument, procedure, null hypotheses, and method of analysis.

Chapter 4 provides a description of the sample, the research questions, and testing of the hypotheses.

Chapter 5 contains a summary of the data analysis, discussion of the findings, implications, recommendations for counselor education programs, recommendations for future research, and conclusion. Appendices, a list of references, and a vita are located at the end of this document.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

The term *codependency* has become a household word (Lindley, Giordano, & Hammer, 1999). Popular psychology has brought codependency into public awareness through a variety of media, ranging from television talk shows to the self-help literature. With this popularity comes confusion, overgeneralization (Gomberg, 1989; Haaken, 1993; Mannion, 1991), blaming, and self-diagnosis (Asher & Brissett, 1988; Frank & Bland, 1992; O'Gorman, 1993). Clients attend therapy sessions assuring their therapists of the accuracy of this self-diagnosis. The codependency construct, having been broadened to mean so many different things to different people, is in danger of meaning absolutely nothing (Lindley et al., 1999).

This confusion is evident in the popular and professional literature alike. Some considered codependency to be a personality style, perhaps even synonymous with dependent personality style (Hinkin & Kahn, 1995). Others considered it to be a social construct, an unfortunate result of social inequality and socialized gender role (Granello & Beamish, 1998). One thing is clear: As prevalent as the notion of codependency is, this construct warrants careful consideration. In order to gain a better understanding of codependency, it is important to define and conceptualize codependency as outlined in the current professional literature, to consider the role of codependency as a personality

style and a social construct, to examine its interrelatedness with family dynamics, and to discuss possible therapeutic interventions.

Background Information

The conceptualization of codependency began in the 1940s when the wives of Alcoholics Anonymous members formed a group, later called Al-Anon, to discuss their problems that seemed to result from living with alcoholic spouses (Crester & Lombardo, 1999). The word codependent, however, was not coined until about 1979 and was used to refer to people who had become dysfunctional as a result of living in a relationship with an alcoholic (Gierymski & Williams, 1986). The term came to describe the dependency needs of two people and their dysfunctional attempts to meet these needs. O'Brien and Gaborit (1992) suggested that the codependent fulfills the need of the alcoholic to be cared for, and the alcoholic fulfills the need of the codependent to be in control. These authors maintained that there was an initial, exclusive association of codependency with chemical dependency. This association was mainly due to the fact that non-codependents were thought to have a strong enough sense of autonomy and self-worth to refuse to tolerate the behaviors of an active chemical dependent.

Whereas Mendenhall (1989) restricted the application of the codependency construct to chemically dependent individuals, other theorists suggested that codependency is a phenomenon that can exist independent of chemical dependency (Cullen & Carr, 1999; Schaef, 1986; Wegscheider-Cruse, 1985; Whitfield, 1989). Morgan (1991) stated that when the chemically dependent person in the family stops using substances, the other family members often continue or even worsen their codependent behavior. Today, the prevalent perspective seems to consider codependency

as being independent of chemical dependency. An estimated 40 million Americans are thought to be codependent, many of whom are female (Hughes-Hammer, Martsolf, & Zeller, 1998a).

Cermak (1986) suggested that some confusion arises when using this broad term since it is used in three different ways: as a didactic tool, a psychological concept, and a disease entity. Morgan (1991) indicated that using the term as a didactic tool may help an individual normalize feelings that are being expressed and allow family members to begin to understand their own interpersonal dynamics. This new understanding will hopefully facilitate a shift within the family from a mode of blaming the identified patient to one of taking personal responsibility in which family members begin to identify and work on their own issues. Cermak (1986) stated that when codependency is used as a psychological concept it may be used to facilitate communication among clinicians to describe and explain human behavior. Finally, Cermak considered codependency to be a disease entity in which the individual has a consistent pattern of traits and behaviors that lead to significant dysfunction.

Codependency Defined

Several theorists (O'Brien & Gaborit, 1992; Whitfield, 1987; Wright & Wright, 1991) defined codependency as suffering or dysfunction that results from focusing on the needs and behaviors of others. Beattie (1987) stated that a codependent gravitates toward care-taking, people pleasing, and other-centeredness that result in the individual abandoning self. Many considered codependent individuals to have been significantly affected in specific ways by involvement in a long-term stressful family environment (Fischer, Spann, & Crawford, 1991; Fuller & Warner, 2000; Prest & Protinsky, 1993;

Schaef, 1986; Van Wormer, 1989; Wegscheider-Cruse, 1985). Prest and Protinsky (1993) indicated that stressful family-of-origin experiences typically result in fear, shame, guilt, despair, anger, denial, rigidity, and impaired identity development.

Whitfield (1991) reported that at the 1990 annual conference, the National Council on Codependency developed the following definition of codependency:

> Codependency is a learned behavior, expressed by a painful dependence on people and things outside the self in an attempt to find safety, self-worth, and identity. These dependencies include neglecting and diminishing of one's own identity. The false self that emerges is often expressed through compulsive habits, addictions, and other disorders that further increase alienation for the person's true identity, fostering a sense of shame. (p. 10)

Whitfield (1989) articulated the viewpoint of Codependents Anonymous regarding codependency. From this perspective, codependency is considered to be a condition in which individuals obtain their self-worth by receiving approval from others. Codependents are seen as spending tremendous energy trying to protect significant others and paying more attention to the feelings and desires of other people than to their own since they believe that the quality of their lives depends on the lives of other people. As a result, codependent individuals spend the majority of their time sharing the interests and hobbies of others at the expense of pursuing their own interests. Whitfield suggested that codependents sacrifice their own values to be close to others.

Codependency Characterized

Codependency in individuals is typically characterized by a loss of self (O'Brien & Gaborit, 1992; Whitfield, 1989). These individuals focus so narrowly on what is happening with those around them that they lose touch with their own thoughts and feelings (Lindley et al., 1999). Codependents have a tendency to live vicariously through

the experiences of others. They attempt to control significant others (Beattie, 1987; Cermak, 1986; Fagan-Pryor & Haber, 1992; Schaef, 1986; Wegscheider-Cruse, 1985; Wright & Wright, 1991) since they are vulnerable to being controlled and controlling others gives them a sense of fulfillment (Fagan-Pryor & Haber; 1992).

O'Brien and Gaborit (1992) suggested that codependent individuals may find themselves agreeing to do things they do not really want to do, or doing more than their fair share of the work. They are attracted to needy people. The authors also stated that codependent individuals attempt to anticipate the needs of others. Typically, codependents assume a tremendous amount of responsibility for the lives of other people (Hughes-Hammer et al., 1998b; Irwin, 1995; O'Brien & Gaborit, 1992; O'Gorman, 1993; Wright & Wright, 1991).

Codependents seek the approval of others to build their own esteem and confidence (Frank & Bland, 1992; Spann & Fischer, 1990; Treadway, 1990). Research conducted by Lindley et al. (1999) considered codependency with regard to the variables self-esteem, succorance, and autonomy. Results demonstrated a negative relationship between codependency and self-confidence and a positive relationship between codependency and succorance. These researchers considered succorance, the soliciting of support and nurturance from others, to be used to compensate for a weak sense of personal identity.

Lindley et al. (1999) challenged the assumption that codependents lack autonomy, interjecting that the accuracy of this assumption depends on the type of autonomy considered. Behavioral autonomy represents the dependent individuals' ability to independently manage the daily events of their lives, such as going to work or performing

household chores. Results of this investigation revealed that, although codependents are behaviorally autonomous, they lack emotional autonomy. The individual remains dependent on others for approval and acceptance.

Collins (1993) suggested that codependents possess a need to be needed and a willingness to suffer. They are in constant emotional pain and often feel helpless because of not getting their needs met. Collins reported that codependents continually invest themselves in others even to the point of being detrimental to self. In an attempt to control the emotions of a significant other, a codependent may continually cater to the needs of the other person believing that the person will be obligated to give the codependent the love that he/she wants. Collins cautioned that often these attempts are neglected or resented by the recipients rather than rewarded by love. This rejection leads to feelings of inadequacy, a sense of having behaved inappropriately, and a sense of needing to do more. Cermak (1991) believed that in an effort to cope with these perceived rejections, codependents use a variety of defense mechanisms such as denial, rationalization, and projection. As these defenses are utilized more frequently, they become unable to recognize their true feelings or take care of their own needs.

A factor analysis completed by O'Brien and Gaborit (1992) supported the usefulness of the codependency construct. In this study, five prominent characteristics of a codependent emerged. First, codependent individuals engage in the caretaking of others to gain a sense of self-worth. Second, these individuals have an external locus of control, placing the interests of others ahead of their own and shaping their lives around the goals of other people. Third, codependents surrender their own values and needs in order to protect the relationship. Fourth, they possess faulty communication skills and often make

inaccurate assumptions rather than enter into direct dialogue with others. Fifth, codependent individuals lack emotional autonomy, gaining their self-esteem through the approval of others and gaining a sense of identity from whom they are with rather than from who they are.

A study conducted by Springer et al. (1998) further explored the relationship between codependency and self-esteem. These researchers gave 217 undergraduate students a battery of assessments to examine the relationship between codependency and the variables self-esteem, relationship quality, inclusion of self and other, self-consciousness, impression management, and internal locus of control.

Results indicated that there were no significant differences among these variables between males and females. Based on their findings, these researchers described codependents as individuals with low self-acceptance who believe they have little control over their interpersonal relationships, perceiving these relationships to be directed by others. Springer et al. (1998) also noted that codependents appear to be self-conscious and hypersensitive to the opinions of others in social situations. Although codependents have a strong desire to make a favorable impression on others, they seem to doubt their ability to do so. For example, these researchers found that codependents are less likely than non-codependents to make exaggerated claims about themselves in order to positively influence the impression they make on others. Springer and his colleagues (1998) purported that the combination of social anxiety, increased self-consciousness, decreased self-esteem, low interpersonal control, and decreased impression management all yield an individual who typically spends a significant amount of time focusing on personal limitations.

Hughes-Hammer et al. (1998b) indicated that codependent individuals typically experience more preoccupation with real or imagined health-related issues compared to non-codependents. Similarly, Friel and Friel (1986) noted that codependent individuals often experience physical stress-related symptoms, which may include muscle tension, headaches, hypertension, teeth grinding, ulcers, and asthma.

Codependency as a Personality Style

Cermak (1986) suggested that codependency is a personality style characterized by loss of self, denial, constriction of emotions, depression, external locus of control, hypervigilance, compulsions, anxiety, and stress-related complications. There was intense debate (Anderson, 1994; Granello & Beamish, 1998; Loughead, Spurlock, & Ting, 1998; Martin & Piazza, 1995; Roehling & Gaumond, 1996; Wells, Glickauf-Hughes, & Bruss, 1998) surrounding whether to include codependency in the classification system of the *Diagnostic and Statistical Manual of Mental Disorders, Text Revision* (*DSM-IV-TR;* American Psychiatric Association [APA], 2000). Among those who considered codependency to represent a personality style that warrants inclusion in the *DSM-IV-TR* (Cermak, 1984; Kitchens, 1991) confusion existed over whether to classify it under an existing personality disorder or to formulate a separate diagnostic category.

Codependency Compared to Borderline Personality Disorder

Similarities exist between codependency and borderline personality disorder (Morgan, 1991). Morgan believed this comparison to be most evident in the area of anxiety and boundary distortions surrounding close interpersonal relationships. When there is an increase in interpersonal distance, both the codependent and the borderline

individual may fear abandonment, resulting in splitting. Splitting occurs when the persons exhibit "black and white" thinking, seeing their partner as either all good or all bad. Morgan stated that any changes in interpersonal distance may also result in these individuals displaying impulsive and self-destructive acts.

Cermak (1986) made an important distinction between individuals with codependent tendencies and those with borderline traits. The borderline person lacks the ego strength to maintain stable boundaries. In contrast, the codependent person usually possesses the necessary ego strength to maintain separate boundaries but voluntarily gives up his/her boundaries in an effort to strengthen connections with others.

Codependency Compared to Obsessive-Compulsive Personality Disorder

Codependency shares characteristics with obsessive-compulsive personality style (Carson & Baker, 1994). Both are considered to involve issues of control, avoidance of one's feelings, perfectionism, and fear of change. In addition, many consider individuals with an obsessive-compulsive personality and codependent personality style to share a childhood marked by a domineering and intrusive parent who controlled much of the child's thoughts and emotions. This upbringing may result in self-criticism, constant striving for unachievable perfection, guilt, and shame.

Differences exist between codependents and those diagnosed with an obsessive-compulsive personality disorder (Loughead et al., 1998). The extent of preoccupation with orderliness, perfectionism, and mental and interpersonal control at the expense of flexibility, openness, and efficiency is not as pronounced in the codependent.

Codependency Compared to Depressive Personality Disorder

Codependency is considered to share many similarities with depressive personality style (Hughes-Hammer et al., 1998a; Wegscheider-Cruse & Cruse, 1990). Carson and Baker (1994) considered both types of individuals to experience feelings of worthlessness, guilt, and inadequacy and believed codependents are compensating for these feelings by developing a strong superego accompanied by very high standards for performance and morality. Carson and Baker further suggested that when individuals perceive that they have not met these standards, guilt and shame develop. Blame is readily assumed, and the person has feelings of ineffectiveness in being able to gain needed approval and acceptance. Overachieving is an attempt to gain this approval.

Depression has a strong correlation with dependency, sharing three common characteristics: family-of-origin issues, low self-worth, and hiding self. Codependents experience a prevailing state of unhappiness as a result of growing up in a troubled family where thoughts and feelings were not expressed and affection was not openly displayed. Low self-worth results as thoughts about self are centered on criticism, hatred, blame, humiliation, and shame. A "false self" emerges as an individual hides his/her "true self" behind a positive front to cover and control negative emotions.

Despite these similarities between depressive personality style and codependency, Hughes-Hammer et al. (1998b) indicated that there are significant differences. Depression frequently has a biological basis that often necessitates medication. In contrast to people with depression, codependent individuals do not experience the severity of symptoms. In addition, these authors reported that not all individuals suffering from depression experience problems with boundaries or controlling others.

Codependency Compared to Dependent Personality Disorder

The majority of theorists and researchers who considered codependency to be identifiable with an existing *DSM-IV-TR* (APA, 2000) personality disorder contended that codependency strongly aligns with a dependent personality style. Morgan (1991) outlined the history of this connection:

> Kraeplin (1913) stressed the "irresoluteness of the will" of dependent patients and the ease with which they could be seduced by others. Abraham (1924) stated that the typical belief of dependent patients is that there will always be someone there to take care of them and anticipate their every need. Fromm (1947) conceived "receptive orientation" whereby individuals feel lost when they are alone because they believe they cannot do anything without help. Horney (1950) provided a descriptor of dependency that comes very close to contemporary formulations of codependency. According to Horney, healthy adults are capable of autonomous functioning but also need the physical and emotional presence, support, and caring of others. This interdependence is necessary for personal growth and individuality. Neurosis results when we depend too heavily on others for fulfillment and a sense of self. She calls this type of dependency the "self-efficacy solution." (p. 721)

The results of a study conducted by Hinkin and Kahn (1995) are consistent with the idea that codependency may be related to a dependent personality style. Hinkin found that dependency, as assessed by the Minnesota Multiphasic Personality Inventory and Navran's Dependency Scale, was positively correlated with measures of codependence.

Although codependency may be strongly correlated with a dependent personality style, important differences exist between the two (Morgan, 1991). Morgan identified willpower as a fundamental difference between dependent personality style and codependency. Codependent individuals actually believe that they can control the feelings and behaviors of others by sheer force of will. When they do not get the results they hope for, codependent people either try harder by attempting to exert their will even further or they give up and feel hopeless and inadequate. Morgan considered identity

confusion to be another difference between codependent individuals and individuals with dependent personality disorder. Identity confusion is frequently associated with codependent individuals since they appear to base their self-worth on their partners' success or failures. If their partners are not happy, codependent individuals feel responsible for making their partners happy. A third difference Morgan identified is the presence of denial. Codependents deny their own feelings and needs and deny their inability to rescue others.

Inclusion of Codependency in the *DSM-IV-TR*

Several researchers have conceptualized codependency as a separate personality disorder and called for its inclusion in the *DSM-IV-TR* (APA, 2000). Growing support for this inclusion is evidenced by recent legislation passed in Pennsylvania authorizing third-party reimbursement for the treatment of codependency. In addition, there are lobbying efforts for the approval of similar legislation in other states (Anderson, 1994). Proponents contend that the codependent personality construct is different from other diagnosable personality disorders in that it is considered to be intentional. Codependent individuals possess the necessary ego strength but voluntarily yield their ego boundaries in order to strengthen their connections with others. They continue a relationship with an addictive partner in order to satisfy their own needs (Granello & Beamish, 1998).

Proponents who attempted to operationalize the concept suggested that codependent characteristics are trait-like and exist to varying degrees across the entire population (Loughead et al., 1998). Cermak (1986) argued that codependence is both a personality trait and a personality disorder, which is consistent with the approach of the *DSM-IV-TR* (APA, 2000):

> Personality traits are defined as enduring patterns of perceiving, relating to, and thinking about the environment and oneself which are exhibited within a wide range of social and personal contexts. Only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress do they constitute Personality Disorders. (p. 686)

Cermak (1986) stated that, although codependent traits exist, the diagnosis of codependency may be made based on the dysfunction resulting from excessive rigidity or intensity associated with certain definable traits. He has constructed the following five criteria for a proposed diagnostic category of codependent personality disorder:

1. Continued investment of self-esteem in the ability to influence or control the feelings and behaviors of self and others in the face of obvious adverse consequences for doing so (Codependents suffer from a distorted relationship with willpower, and they invest an inordinate amount of energy in efforts to improve other people in their search for self-worth.)

2. Assumption of responsibility for meeting others' needs

3. Anxiety and boundary distortions surrounding intimacy and separation

4. Enmeshment in relationships with personality disordered, chemically dependent, impulse disordered, and other codependent individuals

5. Three or more of the following: constriction of emotions, depression, hypervigilance, compulsions, anxiety, substance abuse, excessive denial, recurrent physical or sexual abuse, stress-related medical illness, or a primary relationship with an active substance abuser for at least 2 years (pp. 724-725).

Cermak's (1986) proposed diagnostic criteria incorporate the majority of codependency characteristics detailed in the professional literature. Currently, these proposed diagnostic criteria can be best defined within the *DSM-IV-TR* (APA, 2000)

category of Personality Disorder Not Otherwise Specified. This classification exists when an individual does not qualify for a single personality diagnosis but demonstrates features that together cause clinically significant distress or impairment in one or more important areas of functioning.

An inquiry conducted by Loughead et al. (1998) offers some insight into this longstanding debate. In this study, 37 self-identified codependents were administered the Millon Clinical Multiaxial Inventory-II (MCMI-II) and the Spann-Fischer Codependent Scale. For codependent participants, the MCMI-II diagnostic indicators revealed elevated Avoidant and Self-Defeating scales, reflecting problematic avoidant and self-defeating coping styles. According to Millon (as cited in Loughead et al., 1998), individuals who possess avoidant coping patterns have a tendency to be behaviorally guarded, interpersonally aversive, and cognitively distracted. They demonstrate an alienated self-image, internalization, anguished mood, and an unfulfilled desire to relate to others.

Millon (as cited in Loughead et al., 1998) considered people with self-defeating coping styles to have a tendency to be cognitively inconsistent and interpersonally submissive, frequently relating to others in a self-sacrificing manner. He suggested these individuals appear to seek out situations that bring about hurt, often receiving a measure of pleasure from the experience.

Additionally, results of the investigation conducted by Loughead et al. (1998) revealed that individuals considered being codependent had Passive/Aggressive, Dependent, and Schizoid scales that were elevated. This profile indicates a tendency to depend on others for nurturance and security, yet remain ambivalent in interpersonal

relationships. These individuals appear to be detached from the rewards and demands of interpersonal contact, and they possess an inability to resolve conflict.

Relating these results to Cermak's (1986) proposed diagnostic criteria for codependency, it can be seen that, although codependency shares some MCMI-II scale elevations with other personality disorders, the profile contains some distinctive features. The elevations of the Self-Defeating scale partially support his first criterion, the investment of inordinate amounts of energy in efforts to improve other people in their search for self-worth. Results also support his third criterion for a diagnosis of codependency disorder: anxiety and boundary distortions surrounding intimacy and separation. However, no support was found for criteria 2 and 4 regarding responsibility for others and enmeshment. In fact, the Alcohol Dependence and Drug Dependence scales were not elevated, indicating little evidence of substance abuse among those who are codependent.

The Dependent Personality Disorder profile looks somewhat similar to the codependent profile. However, elevations of the Avoidant and Self-Defeating scales present in the codependents' profiles were not elevated to the same degree as the Dependent Personality Disorder scales. Furthermore, the Dependent Personality Disorder profile showed an elevation on the Dysthymic scale not present in the codependents' profile.

Codependent Personality Style and Personal Vulnerability

Aside from considering codependency in terms of a *DSM-IV-TR* (APA, 2000) diagnosable personality disorder, a study undertaken by Wright and Wright (1999) conceptualizes codependency as a personality style resulting from personal vulnerability. Results indicated that individuals may possess a personality style that predisposes them to form and maintain codependent relationships. Originally, theorists postulated that anyone involved in a relationship with an exploitive partner would likely develop into a codependent. However, they found no support for this theory and recognized that people differ in their vulnerability to manipulation and are unlikely to become a codependent in the absence of personal susceptibility. As a result of their work, Wright and Wright have proposed two different types of this personal susceptibility, which produce similar but not identical patterns of codependency relating. Codependency may be conceptualized as either endogenous or exogenous.

Endogenous codependency corresponds to the trait view of codependency. These individuals are not only vulnerable to becoming codependent, but they are likely to gravitate toward and become enmeshed in codependent relationships. Findings support the proposition that endogenous codependency results from having been reared in a dysfunctional family but avoids suggesting that anyone reared in such a family will become an endogenous codependent.

People who become exogenous codependents are "normal" individuals whose socialization has emphasized compassion, cooperativeness, self-forgetful caring, and concern for the well-being of others. Wright and Wright (1999) indicated that these individuals do not come from a dysfunctional family of origin, but rather have been

reared in supportive homes that encourage healthy interdependence. Persons with such an orientation may never become involved with exploitive partners and, therefore, never become codependent relaters. On the other hand, if they should become involved, they are vulnerable to being manipulated into caretaking roles by their partners. Although these individuals are in unrewarding relationships, they often have reasonably fulfilling lives apart from those relationships.

Wright and Wright (1999) suggested that it may be helpful for the therapist to recognize important differences between endogenous and exogenous codependents. Compared to exogenous codependents, endogenous codependents have a more difficult time changing behavior and relationship patterns in response to therapy. This difficulty may be attributed to their greater likelihood of involvement in repeated dysfunctional relationships. A large amount of time in therapy is spent on past problems from the family of origin as well as present problems with contemporary relationships. In contrast, exogenous codependents are more responsive to therapeutic attempts to change relational attitudes, behaviors, and self-perceptions. Their responsiveness may be because they have been involved in fewer dysfunctional relationships. Because family-of-origin issues are minimal, most of their therapeutic time may be spent on "here and now" problems in current relationships.

Etiology

Historically, codependency was thought to develop in children raised by parents who were substance abusers (Carson & Baker, 1994; Cermak, 1991; Gotham & Sher, 1996; Lyon & Greenburg, 1991). Researchers have since acknowledged that parental substance abuse is neither necessary nor sufficient for the development of codependency

(Crothers & Warren, 1996; Cullen & Carr, 1999; Fischer et al., 1991; Fuller & Warner, 2000; Irwin, 1995; O'Brien & Gaborit, 1992). Fuller and Warner (2000) reported that what appears to be a correlation between codependency and parental substance abuse may be merely a reflection of the dysfunctional aspects of family life that are related to the presence of a chemically dependent parent. The research of Prest, Benson, and Protinsky (1998) provided support for the notion that general dysfunctional dynamics in the family of origin play a significant role in the development of codependent relational patterns.

Influence of the Family of Origin

Many different dysfunctional family-of-origin patterns are believed responsible for fostering and maintaining codependency: childhood abuse (Borovoy, 2001; Carson & Baker, 1994; Morgan, 1991), parental cohesion and non-nurturance (Crothers & Warren, 1996; Teichman & Basha, 1996), authoritarian paternal parenting style (Fischer & Crawford, 1992), inadequate parental bonding (Burris, 1999), repressive family atmosphere (Cullen & Carr, 1999), physical or verbal abuse (Beattie, 1987), lack of support (Fischer & Crawford, 1992), and high levels of enmeshment (Fischer & Crawford, 1992).

Haaken (1993) considered codependent relational patterns such as an extreme sensitivity to the needs of others to be learned by children to overcompensate for parental inadequacies. Burris (1999) suggested that a codependent personality develops to help the child adapt to his/her home environment. The child quickly learns that his/her personal well-being depends on the parents' needs being met. The child's hypersensitivity and

emotional repression serve as his/her attempt to manage anxiety and other unpleasant feelings that accompany growing up in an oppressive home.

Wells, Glickauf-Hughes, and Jones (1999) investigated the popular claim that codependency is a shame-based personality organization characterized by lower self-esteem. These researchers examined the association between codependency and the constructs of shame-proneness, guilt-proneness, lower self-esteem, and parentification. Students from an introduction to psychology class at a large southeastern university were administered four questionnaires reflective of these areas.

Results indicated that codependency was positively correlated with internalized shame, whereas a negative correlation was found between codependency and guilt. Shame results when individuals view the true self to be defective or inadequate. As a result, these individuals develop a shame-based false self that is other-oriented and over-conforming. Shame is a sense of "being" bad that leaves one with lowered self-esteem and feelings of hopelessness. Guilt is feeling bad about "doing" something wrong or hurtful. Individuals in this sample who subscribed to more codependent characteristics reported being less prone to guilt feelings over specific behaviors. Rather, they indicated feeling generally inadequate and defective as a person. Wells et al. (1999) concluded that codependency reflects a specific way of viewing one's self, as opposed to a style of responding to particular behaviors.

Wells et al. (1999) also stated that the codependent individuals in their study typically came from families in which there was parentification, the reversal of the parent-child role. These researchers theorized that needy parents frequently attempt to get their needs met by seeking care giving from their children. In order to maintain

connection to the parents, children must strive to meet the parents' needs, sacrificing their true self for a codependent, false self. Wells et al. further indicated that even after these children reach adulthood, they continue to demonstrate parentified behaviors in their current relationships. In short, codependent relational patterns are learned during childhood when children are not able to get their own dependency needs met within their family of origin. The authors considered this phenomenon to be especially prevalent in shame-based families.

Cullen and Carr (1999), family systems advocates, examined the family-of-origin dynamics of codependents. Contrary to common belief, the group who scored high on codependency measures did not contain more individuals whose parents had substance abuse problems. In addition, this group did not contain individuals who experienced a higher incidence of childhood abuse compared to those who scored low on codependency measures.

Cullen and Carr (1999) noted that individuals who scored high on codependency measures reported significantly more family-of-origin concerns and parental mental health problems compared to the noncodependent scorers. Specifically, participants reported difficulties in terms of the clarity of roles, the quality of communication, the level of emotional expressiveness, the level of emotional involvement, the level of behavioral control, and the quality of values and norms. Reportedly, the area of greatest concern was difficulty with emotional expressiveness.

Cullen and Carr (1999) suggested that difficulty with emotional expression in the family of origin may create difficulty in the open expression of feelings later in adulthood. For example, children of parents who have mental health problems may adopt

caretaking roles that are unhealthy, are rigid, and involve high levels of denial. These family roles continue into adulthood where individuals continue to search for a sense of purpose by engaging in caretaking relationships. Cullen and Carr speculated that these types of family dynamics foster a belief in personal powerlessness and the powerfulness of others.

These researchers interpreted the results of their investigation to suggest that codependency is one aspect of a larger multigenerational family systems problem that is not unique to substance abusers or other types of abusive families. Children who grow up in families where roles are not clear, where emotions are repressed, and where parents have mental health problems are susceptible to codependency.

Similarly, an investigation by Teichman and Basha (1996) used Olson's circumplex model of family relationships. In this model, Olson looks at two interrelated dimensions: cohesion and adaptability. Cohesion is the emotional relationship among family members. Adaptability is the ability of the family system to change roles and rules as needed. A family that is balanced in these two areas is considered to be able to function well. In contrast, Olson considers a family that is found to be at the extremes on these two variables to be pathological.

Consistent with Olson's perspective, Teichman and Basha (1996) considered a family that is at either extreme on cohesion or adaptability to foster codependency. Low cohesion was marked by emotional alienation, distance, lack of loyalty, and lack of dependence whereas high cohesion was marked by excessive emotional involvement, extreme loyalty and support, enmeshment, and strong dependency. Low adaptability

featured lack of order, rapid changes in roles in the family, and inconsistency in behavior, whereas high adaptability was marked by inflexibility, strong discipline, and rigid roles.

Fischer and Crawford (1992) examined the effects of parenting style on the development of codependency. Adolescents scoring higher on codependency, as measured by the Spann-Fischer Codependency Scale, scored lower on self-esteem and intimacy but higher on anxiety, depression, and external levels of control. Fischer and Crawford suggested that late adolescents and young adults may attempt to resolve some of their developmental issues with intimacy through a codependent pattern of relating to others. This pattern may develop as a result of a parenting style experienced in the family of origin. These researchers examined maternal and paternal parenting style on two variables: control and support. Paternal parenting style proved to be a stronger indicator than the maternal parenting style for fostering codependency.

Fischer and Crawford (1992) contended that a permissive parenting style, characterized by low control and high support, is associated with an adolescent who demonstrates dependency and immaturity. Uninvolved parents were characterized by low control and low support. As a result of this investigation, these researchers believed that permissive and uninvolved parenting leads to fewer codependent adolescents because control issues have not been a prevalent issue.

Fischer and Crawford (1992) also found that an authoritarian parenting style, marked by high control with low support, frequently led to a child with lower self-esteem and a higher level of codependency. The authors mentioned that adolescents raised in authoritarian families demonstrated a higher prevalence of codependent relational patterns when compared to permissive parents. Adolescents in the authoritarian families

struggled with control dynamics because they did not feel supported and considered the control to be arbitrary. In families where parents offered low support, typical of the uninvolved and authoritarian parenting styles, adolescents were needy in their relationships with others.

Finally, Fischer and Crawford (1992) found that democratic families with high control and high support produced adolescents with more self-control and maturity. In these families, control was experienced in the context of caring and warmth from parents and was not seen as punitive or arbitrary.

Burris (1999) believed codependency to be predicted by bonding style with the same gender but not the opposite gender parent. Burris attributed this to the fact that the codependent's mother often has a greater history of codependent relationships with individuals who tend to be exploitive. As a result of this relational history, the mother may be so absorbed in the codependent relationship that she is unable to adequately attend to her parenting role. Also, a codependent mother typically serves as an unhealthy role model, teaching her daughters codependent ways of relating. Fathers are considered to play a less prominent role in teaching their children about intimacy in relationships. Burris maintained that the impact of fathers on the development of codependency in daughters is more likely to be made through the father's relationship with the mother rather than direct father/daughter bonding.

Four main theories regarding the etiology of codependency dominate the current professional literature: learning theory, developmental theory, object relations theory, and family systems theory. All four theories readily acknowledge the pervasive influence of family-of-origin issues in the development of codependency.

Learning Theory

Burris (1999), a learning theorist, considered codependency to be learned responses to maladaptive relational patterns that occurred in the family of origin. As a result of the dysfunction, the child displays hypervigilant attentiveness to the parent for predicting or preventing unpleasant episodes. The child concludes that fixing the problems of others is a means of preserving one's self-worth. Since the child will have few positive experiences with the caregiver, these positive times are very intense.

Burris (1999) maintained that the child develops codependent patterns of relating in response to a partial reinforcement schedule. The occasional rewards the child experiences during positive interaction with the caregiver are very powerful and result in persistent reward-seeking behaviors. The child often perceives the reward to be the direct result of his/her own effort to "fix" the parent. These early interactions with an exploitive family member are believed to shape the codependent's expectations and relational patterns in future adult relationships.

Burris's investigation consisted of giving female college freshmen from an introductory psychology class the Spann-Fischer Codependency Scale and Parker's Parental Bonding Instrument. One week later, each participant was unknowingly involved in a staged laboratory interaction to determine his/her response to an individual perceived to be nurturing and an individual perceived to be exploitive. Based on the results of this investigation, Burris concluded that a codependent individual would be more attentive and more responsive to exploiting individuals than to nurturing individuals.

Developmental Theory

Friel and Friel (1986) conceptualized codependency in terms of Erickson's theory of development. These authors attributed codependency to arrested identity development. The codependent overreacts to things outside himself/herself and underreacts to things within. Friel and Friel maintained that a sense of basic self is necessary for identity formation.

Object Relations Theory

Carson and Baker (1994), representative of the object relations perspective, viewed the codependent individual as using relationships to find meaning. These relationships are often problematic since the codependent experiences instability of thoughts and feelings, a need to control self and others, and caretaking to the exclusion of care for oneself. A lack of personal identity leads to the emergence of a false self, creating difficulty with intimacy and feelings of alienation from others. The codependent's insecure attachment promotes worries about separation and loss, which leads to feelings of jealousy and guilt. These feelings of insecure attachment are coupled with a feeling of social incompetence, which causes the codependent to be even more withdrawn and uncertain about how to relate to others. Carson and Baker contended that the excessive concern and caretaking of the codependent, based on these interpersonal difficulties, is consistent with reaction formation, the major defense in codependent individuals.

Carson and Baker (1994) maintained that reality-testing difficulties arise as the codependent experiences confusion about the feelings and behaviors of self and others. These individuals often have trouble with accurately perceiving interpersonal situations.

These distortions make relationships more confusing and anxiety-provoking. In an attempt to manage the anxiety inherent in their relationships with significant others, codependent individuals strive to control other people's feelings, behaviors, and thoughts.

Family Systems Theory

The dominant theory in professional literature surrounding codependency is family systems theory. Although the concept of codependency was popularized from work with chemical dependency, family theorists claim to have worked with this concept several decades before, using different terminology and different clinical populations (Scaturo, Hayes, Sagula, & Walter, 2000). Scaturo et al. (2000) provided the example that in 1958 Ackerman used the term "interlocking pathology"; in 1960 Bowen conceived the "over adequate vs. inadequate" relationship, followed in 1963 by Haley's "one-up vs. one-down" relationship, eventually leading in 1972 to Bateson's notion of "complementarity" (p. 64).

Prest and Protinsky (1993) interfaced their concept of codependency with Bowen's intergenerational family systems model. Prest and Protinsky described the basic premises of Bowen's model: Relational patterns are learned and passed down through generations, current individual and family behavior is a result of these learned patterns, the family system is homeostatic, and the family is viewed as a set of interrelated parts wherein a change in one part of the system affects the rest of the system.

Consistent with family systems theorists, Prest and Protinsky (1993) acknowledged that the primary aim of therapy is to achieve a balance between the individuality of each family member and the togetherness of the family system as a whole. Prest and Protinsky echoed Bowen, maintaining that promoting autonomy with

the individual is necessary for the self to be differentiated from the family of origin. These authors pointed out that if this goal of differentiation is not achieved, the family dynamics may be best described using Bowen's pathological condition known as "undifferentiated family ego mass."

Prest and Protinsky (1993) purported that codependency emerges from this undifferentiated family ego mass and the accompanying dysfunctional relational patterns. In an attempt to reduce anxiety, individuals engage in triangulation, fusion, and compulsive or addictive behavior. Individuals in undifferentiated families focus on the lives of other people, which results in their losing their own sense of identity. This lack of individuation is reinforced and transmitted from one generation to the next, resulting in family members having difficulty managing appropriate levels of interpersonal intimacy or distance.

Fagan-Pryor and Haber (1992) also used Bowen's work to conceptualize codependency. From this perspective, people are classified on a continuum of emotional maturity, ranging from undifferentiated to highly differentiated. The level of differentiation a person is thought to possess is determined by what Bowen called the "togetherness force" and the degree of "basic self." The greater the togetherness force, the more the individual's thoughts, feelings, and behaviors are determined by other people and the more undifferentiated the sense of self. The basic self is the part of an individual that changes due to internal forces. For example, intellectual reasoning helps to determine the beliefs and principles of the basic self.

Consistent with Bowen's theory, Fagan-Pryor and Haber (1992) stated that poorly differentiated individuals have little sense of a basic self and consequently allow their

sense of self to be defined by the feelings of others. Undifferentiated individuals are seldom knowledgeable of their own beliefs, expend most of their energy trying to keep the peace, and have a tendency to go from one crisis to another. Fagan-Pryor and Haber articulated that the consequences of poor differentiation include anxiety, physical illness, emotional illness, and social dysfunction.

In contrast, Fagan-Pryor and Haber (1992) maintained that individuals with good differentiation are able to use their intellect to make their own decisions. They can take part in interpersonal relationships without fear of becoming fused with others. Because differentiated individuals have a sense of personal identity, they tend to follow self-determined goals, have clearly defined boundaries, and take responsibility for themselves.

Family systems theory suggested that adults unconsciously choose partners with relatively equal levels of differentiation (Prest & Protinsky, 1993). At first glance, spouses may appear to differ in their level of differentiation, such as alcoholic behaviors versus enabling behaviors. Upon closer examination, these differences are found to be manifestations of similar underlying systemic dynamics used to manage anxiety. When both members of a couple are undifferentiated from their families of origin, a state of emotional fusion exists in the marital relationship causing a decrease in intimacy, individuation, and personal authority.

In a dysfunctional family system, survival of the family is given priority over all the individuals' needs for nurturance. Approval, acceptance, and attention are rarely provided unconditionally to the child in a dysfunctional family. This approval is conditionally based on the attainment of family goals, protecting of family secrets, or

fulfillment of certain family roles. The child depends on these behaviors to elicit family approval and incorporates them into his/her sense of self-worth and identity.

Mellody and Miller (1989) reported that codependent parents do not value their children and rarely allow them to lead their own lives. Codependent parents tend to place a tremendous amount of pressure on their children, expecting them to be perfect. Mellody and Miller also considered these parents to be incapable of nurturing their children or providing them with a stable environment. These authors believed that codependent parents are prone to abusing their children.

Codependency is seen as a progressive process where self-denial and caring for other family members is practiced on the assumption that doing so will earn love, closeness, acceptance, and security in the family. Although the child is given numerous opportunities to care for others, his/her own emotional needs are neglected. The child enters adulthood with a vast amount of unmet needs. These needs may manifest themselves in symptoms of codependency such as extreme sense of responsibility for others, inability to appropriately care for self, and denial. The denial serves as a defense mechanism that protects against a reality that is too painful to allow into conscious awareness. For a child raised in a dysfunctional family, denial becomes a daily means with which to cope and, when carried into adulthood, interferes with his/her ability to recognize personal thoughts and feelings (Clark & Stoffel, 1992).

Granello and Beamish (1998) stated that there are three main criticisms to a family systems approach to codependency. These authors considered this viewpoint to ignore the unequal distribution of power that is often present within families. For example, women develop subtle, codependent behaviors to obtain control within the

family because often overt power and control lie beyond their reach. A second criticism raised by Granello and Beamish is that the family systems model does not take into consideration contemporary knowledge about women and women's positions in families. For example, differentiation of the self is stereotypically a male characteristic. A third criticism held by Granello and Beamish is that the family systems model tends to place blame on the family system as opposed to holding individual family members more accountable.

Codependency as a Social Construct

Although the majority of literature portrays codependency as a personality disorder, some argue that codependency is a result of societal disorder and inequality. Granello and Beamish (1998) considered codependency to be a prime example of how social problems are attributed to family and individual pathology. These authors suggested that ascribing to the codependency construct frequently results in blaming the victim while ignoring political, economic, and social contexts. Cowan et al. (1995) suggested that the symptoms associated with codependency are merely the behaviors that people in a subordinate position adopt to survive in the dominant culture.

Clark and Stoffel (1992) indicated that social systems can perpetuate codependent behaviors. For example, in some professions it is common for employees to work overtime, and this behavior is sometimes deemed "necessary" for success. An individual may choose to work a large amount of overtime because he/she wants to gain recognition and approval from employers rather than because of realistic job responsibilities. Within the world of work, this behavior is frequently rewarded and admired.

Codependent traits of individuals may influence their career choices as they seek to get their codependent needs met in socially sanctioned ways. Martsolf, Hughes-Hammer, Estok, and Zeller (1999) used the Codependency Assessment Tool to measure the prevalence of codependency among helping professionals. Their results indicated that relatively low rates of codependency were present.

Clark and Stoffel (1992) examined the relationship between codependency and care-giving to gain a better understanding of whether codependent persons are attracted to care-giving professions. In this study, the researchers compared the codependency scores of 15 occupational therapy students with 15 health administration students using the Friel Codependency Assessment Inventory. Contrary to the researchers' predicted outcome, the occupational therapy students did not report a higher level of codependency traits compared to the administration students. Clark and Stoffel interpreted these results to mean that there was not a significant positive correlation between codependency and choice of a care-giving-oriented profession.

The extent to which an individual's codependent traits serve as a motivational factor in choosing a career in nursing has also been considered. Mancuso (1998) suggested that a significant number of nurses may exhibit signs of codependency. Mancuso indicated that because of this prevalence, it is important for nursing educators and nursing curriculum to address nursing students' relational patterns. In contrast, Parker, Faulk, and LoBello (2003) assessed 35 nursing students' level of codependency using the Codependency Assessment Inventory and found that codependency was a problem for only a small number of the nursing students. They concluded that codependency was not prevalent enough in their students to warrant curricular attention,

but, rather, stressed the importance of faculty awareness so that identified students could be referred for counseling.

Codependency and Female Gender Role

Schaef (1986) and Whitfield (1989) estimated that 96% of the female population in the United States may experience codependency. Critics of the codependency construct consider codependency to be discriminative, pathologizing behaviors associated with the female gender role (Chiauzzi & Liljegren, 1993; Cowan & Warren, 1994; Granello & Beamish, 1998; Haaken, 1990; Van Wormer, 1989). Granello and Beamish (1998) have contended that there are oppressive sociopolitical influences that shape the personality of women that are overlooked in the conceptualization of codependency.

Cowan and Warren (1994) argued that the model of mental health in the United States is based on masculine stereotypes in which autonomy is valued. These authors note that the model fails to take into account women's perspectives in which connection, rather than autonomy, is the goal. By using the male as the norm for defining mental health, the concept of codependency pathologizes women for their socially prescribed gender role. Granello and Beamish (1998) insisted that women are taught to be nurturing and to put their family members' needs before their own and then risk criticism for being enmeshed with their families. Similarly, Anderson (1994) stated that, in many cultures, women are socialized to be dependent, to have lower self-esteem, and to live vicariously through others.

Granello and Beamish (1998) argued that codependency focuses on the symptoms of the individual rather than on the symptoms of society. They urged that the focus should not be on the need for women to change but rather on changing the system. This

stance does not suggest that women be encouraged to remain in unhealthy relationships. Rather, their attempts to remain in these relationships should not be understood as pathological, as a male standard might suggest, but rather recognized as feminine strength and resiliency.

Granello and Beamish (1998) further indicated that a strength of the codependency construct's strong association with the female gender role is that it highlights the tendency of women to value connectedness. Webster (1990) stated that women's attempts to maintain difficult relationships can be considered a strength rather than a characterological disorder. Webster also stated that women's desire for connectedness is demonstrated in their focus on empowering others. Wright and Wright (1991) suggested that women have been strongly socialized to express compassion, practice cooperativeness, and have an interest in the welfare of those around them.

Miller's (1986) self-in-relation theory maintained that women naturally seek mutually empathetic connections in relationships. This view is contrary to society's emphasis on the value of independence and separation. A woman's sense of self develops not as a result of movement toward autonomy and individuation but rather through interpersonal connection and interactions with others. Women tend to define themselves by the nature and success of their relationships. Miller has contended that attempts to preserve relationships, in spite of great personal cost, are attempts to hold onto self-identity.

Miller (1986) indicated that when women are unable to participate in a mutually responsive relationship, depression, anger, isolation, confusion, and a decreased sense of well-being may ensue. Women will make every effort to change themselves into an

image they believe will be accepted in a connecting relationship. Collins (1993) maintained that the problem should not be framed as women's desire to form these connecting relationships but rather in their partners' inability or unwillingness to relate in a mutually responsive way.

Martsolf, Sedlak, and Doheny (2000) have offered support that is contrary to this popular view that codependency is inherently connected to the female gender role. Since older females are typically considered to be representative of traditional female roles more than younger women, these researchers examined group differences based on age with regard to codependency. Contrary to popular belief, the older women did not score higher on measures of codependency when compared to younger women. Ninety-nine percent of the older women, age 65 or older, received relatively low codependence scores.

Gender Differences

Perhaps some confusion regarding the extent of association between codependency and the female gender role may be attributed to the specific codependency assessment instrument utilized. Fuller and Warner (2000) examined the prevalence of codependency with regard to gender differences on two of the main instruments used in codependency research: Spann-Fischer Codependent Scale and Potter-Efron Codependency Scale. Results indicated that females were more codependent than males according to scores on the Spann-Fischer but not the Potter-Efron scale.

Fuller and Warner (2000) interpreted these findings to mean that men and women do not report equally the different components of codependency measured by these scales. For example, men may be more willing to report that they have certain

characteristics that are included in the Potter-Efron scale such as rage, rigidity, and denial than they are to report characteristics that are included in the Spann-Fischer scale such as worry, guilt, or painful relationships. Codependency, as defined by the Spann-Fischer scale, seems to be more acceptable to women, and perhaps more consistent with female gender role stereotypes, whereas the definition of codependency in the Potter-Efron scale contains elements that seem more acceptable to men and their stereotyped gender role.

Wright and Wright (1990) examined the relationship between gender role and codependency. Their results suggested that the profile for a codependent female differs from that of a codependent male. Specifically, these researchers examined eight common characteristics of codependency. Codependent women fit most, but not all, of the clinical profiles for codependency, reporting five of the eight characteristics: control, exaggerated responsibility, worth dependency, rescue orientation, and change orientation. The women indicated an excessive dependence upon their partner for a sense of self-worth, a tendency to control him, an exaggerated sense of responsibility for him, and a conviction that they had rescued him and were the major influence in changing him for the better.

Wright and Wright (1990) found that the codependent profile for males contained only two of the eight characteristics of codependency: control and exaggerated sense of responsibility. A codependent man may show a strong tendency to control his partner and to take responsibility for her behavior and well-being. However, he will not necessarily feel that he has rescued her, tried to change her, or needed her for his own sense of self-worth.

Codependency and Powerlessness

Cowan et al. (1995) disagreed with the popular belief that codependency is a social condition attached to the female gender role. Results of their investigation did not find any gender differences with regard to codependency. Both male and female participants who scored higher on measures of codependency perceived themselves as having less power in their relationships than did participants with lower codependency scores. In addition, the more participants reported a loss of self, the more their relationships were characterized by powerlessness, inability to make decisions, and use of indirect strategies to get their own way. Cowan et al. believed codependents assume the subordinate posture in a relationship regardless of the actual power differential. This submissive role is taken in an attempt to find validation of their identity and worth.

Cowan et al. (1995) maintained that powerlessness in relationships is experienced equally by both men and women. These authors believe subordination in relationships may come from different sources such as experiences in the family of origin, employment experiences, and the amount of involvement in the relationship itself. Codependency is associated directly with power and thus only indirectly associated with gender.

A Codependent in the Family

A synthesis of the research suggests that regardless of whether codependency is viewed as a personality style or a social construct, existing relational patterns of the codependent may significantly impact family dynamics. The marriage of a codependent individual is typically problematic. Initially, the relational pattern between a codependent and his/her spouse may appear to represent genuine caring and concern. The codependent believes that he/she finally has someone to fully appreciate his/her care giving, whereas

the noncodependent believes he/she is finally cared for. This marital relationship often is shallow and lacks intimacy, since it is based on the loss of personal identity rather than on two people sharing their developed true identities. Eventually, bitterness may become evident as the codependent begins to resent relinquishing his/her own desires and the noncodependent begins to resent being controlled.

Springer et al. (1998) considered codependents to be more anxious, insecure, and avoidant about relationships when compared to non-codependents. These authors contend that codependents have an intense desire for closeness in their relationships, but at the same time fear intimacy. Springer et al. indicated that because of past relational experiences, codependents typically feel a sense of shame, anger, and despair, believing that no one is as willing as they are to commit to a relationship. As a result of this insecurity, codependents tend to hold their spouses in obsessive regard and are intensely jealous and possessive of their spouses' attention. This jealousy stems from a fear of abandonment and results in the individual having difficulty with trusting, feeling misunderstood, and questioning their worthiness to be loved. Springer et al. stated that although codependents are likely to experience emotional empathy for their spouses, they do not demonstrate this support for their spouses. Codependents reported higher feelings of competitiveness in their relationships compared to non-codependents.

Carson and Baker (1994) maintained that parent-child relationships may also be problematic and marked by contradiction. Codependent parents have difficulty allowing children to possess their own identity, seeing the children merely as an extension of the parents themselves. As a result, a codependent's shame and self-hate is aimed toward the child. The codependent parents place unrealistic pressures on the children to be perfect.

Ironically, because of the codependent parents' insecurity, any success experienced by the children may result in jealousy on the part of the codependent parents. This jealousy leads to hostility and criticism toward the children. Codependent parents may even compete with their children for the attention and approval of the noncodependent spouses.

Carson and Baker (1994) stated that the children may begin to believe that they are not worthy of being noticed and that they must be guilty of something to cause their parents' disapproval. Typically, the children will repeatedly set higher goals in an attempt to secure the approval and love of their codependent parents. Inability to reach these unrealistic goals leads the children to believing that they are a failure. The children try to manage their resulting anxiety by attempting control of others by doing for them and anticipating their thoughts and needs. In this process, the children suppress awareness of their own feelings and needs, abandoning their true selves.

Opposition to the Codependency Construct

Opponents of the codependency construct have argued that it lacks diagnostic discriminative validity (Anderson, 1994; Chiauzzi & Liljegren, 1993; Gierymski & Williams, 1986; Haaken, 1990). Some researchers have contended that the codependency construct lacks theoretical and empirical support (Anderson, 1994; Chiauzzi & Liljegren, 1993; Gierymski & Williams, 1986; Irwin, 1995).

Irwin (1995) protested that even proponents of the concept seem unable to agree as to whether it is a psychological disorder, a personality trait, or a social condition. Definitions describe diverse symptoms that range from simple problems in daily living to reality distortions. Anderson (1994) maintained that investigations considering

codependency have yielded inconclusive results. For example, personality disorders are generally considered to be recognizable by age 16 and highly resistant to change. However, adult children of alcoholics, who are well-known codependents, improve rapidly in therapy.

Opponents also have objected to the current conceptualization of codependency because it has become a buzzword that lends itself to overuse and self-diagnosis, encompassing anyone who has interpersonal problems (Asher & Brissett, 1988; Frank & Bland, 1992; O'Gorman, 1993). Anderson (1994) stated that these overgeneralizations lead to stereotyping clients and denying their uniqueness, as well as promoting a static approach to dealing with the family of origin. Granello and Beamish (1998) admonished that codependency has become big business with an estimated 1,800 Codependency Anonymous groups in the United States alone. Morgan (1991) cautioned that patients could be exploited for characteristics that exist to varying degrees in most people.

Anderson (1994) was opposed to the application of a disease model to interpersonal problems because it is believed to oversimplify a complex phenomenon. Walters (1990) was against applying the disease model to codependency because it appears to trivialize the truly addictive behaviors associated with chemical dependencies that are life threatening. Rather than using a disease model of addiction, Brown (1990) considered codependency to be best explained by means of process addictions. In process addictions, no chemical substance is involved. In the case of codependency, addiction occurs through an interpersonal process that mimics drugs in its effects on people. The codependent person experiences a craving, gets high on the interpersonal process, and

suffers withdrawal symptoms on separation from the significant other. The individual is willing to continue the relationship despite personal cost.

Opponents to codependency also considered the construct to be culturally bound, discriminating against women and subordinates (Anderson, 1994; Collins, 1993; Haaken, 1990). Inclan and Hernandez (1992) cautioned that because of its cultural framework, the codependency construct offers little to individuals from diverse ethnic populations.

Some theorists considered the need for a codependency construct to be unfortunate. Collins (1993) maintained that a codependency focus is misguided since it is not the lack of separation that needs to be addressed, but rather the lack of mutuality in our society that must be addressed. Similarly, Haaken (1993) believed that if codependency were as prevalent in our society as some claim, then codependency would be reframed as positive, and individuals would work toward common goals rather than be urged to recover from such a relationship-oriented outlook.

Therapy Considerations

Prest and Protinsky (1993) cautioned clinicians against indiscriminately labeling people as codependent. These authors stated that both intergenerational relationship dynamics and socialized gender role must be assessed prior to formulating assumptions about whether or not an individual is codependent. Codependent behaviors and attitudes need to be understood within the relational context and not limited to characteristics isolated within an individual.

Addressing Misconceptions

Because of the popularity codependency has received in the media, it is important to address clients' misconceptions and provide them with accurate information regarding the distinction between healthy goals and codependent patterns of behavior. Clark and Stoffel (1992) suggested that a psychoeducational approach that places codependency on a behavioral continuum is helpful. The polar ends of the continuum may be used to make comparisons between a healthy achiever and a perfectionistic codependent. For example, healthy achievers typically set challenging but realistic goals, are able to laugh at self, engage in positive self-talk, and pay attention to details without losing sight of main issues. Healthy achievers assess their own limits, ask for help when needed, focus on their accomplishments, and view aspects of criticism as helpful feedback. In contrast, Clark and Stoffel considered codependent individuals to set unrealistic goals, engage in negative self-talk, be perfectionistic, and obsess over small details. These authors believed that codependents typically do not know how to assess their own limits, are unable to ask for help, dwell on past mistakes, and take criticism personally.

Developing Self-Esteem

A primary issue when working with codependent clients is increasing self-esteem. Springer et al. (1998) indicated that it is important to help clients develop a self-esteem that is based on their own thoughts and feelings, rather than on the approval of others. The goal is for clients to acquire an internalized positive sense of self that includes being able to identify what they want and need, and then acting on their own behalf to fulfill these needs.

Increasing Awareness

Another important issue when working with codependent clients is assisting them to be aware of the impact their relationships are having on them (Springer et al., 1998). Clients may benefit from being taught what a healthy relationship is and from learning skills to establish and maintain these relationships. Clients should be warned that changes might result in unwanted results in their relationships. They need to be reassured of the therapist's support through these difficult times.

Letting Go of the Need to Control

Kitchens (1991) stated that it is important for codependent individuals to learn to give up certain types of control. For example, they need to learn the difference between having control over their own lives and trying to control others' lives. Codependents frequently attempt to control others by acting as "rescuers" and "fixers." They need to realize that these attempts at control heighten the level of stress in relationships and often serve to alienate others. Codependent clients may benefit from recognizing that they have power over only their own choices. A task of the therapist is to help them learn to accept the ambiguity inherent in relationships.

Managing Toxic Shame

Wells et al. (1999) stated that since codependent clients typically perceive themselves to be inherently flawed or inadequate, they may benefit from learning the difference between shame and guilt. Therapy should attempt to help clients learn how to recognize and interrupt feelings of toxic shame. These authors contended that codependent clients will benefit from developing a problem-focused perspective as

opposed to a self-blame perspective. To help clients manage their shame, the therapist can observe clients' patterns of connection and disconnection with self and others and then help clients to understand the role that shame plays in these relational patterns. As clients begin to understand this dynamic, they will be better prepared to reconnect with self and others when they believe that they do not deserve to be in a meaningful relationship.

Healing the Inner Child

Whitfield (1987) believed that treatment should focus on the concept of the "inner child," also known as the "child within," the "real self," or "true self" (p. 9). The inner child refers to the part of the individual that is energetic and creative, the person one really is on the inside. Whitfield stated that people growing up in a limiting family environment learn to deny their inner child. When the true self is not nurtured or allowed free expression, a codependent, false self emerges. Whitfield identified an important goal of treatment to be helping clients heal through nurturing their inner child and grieving the earlier experiences that may have inhibited the development of a healthy inner child.

Attending a Support Group

Morgan (1991) suggested that individuals may benefit most from attending a 12-step recovery group. He believed that group settings often instill hope by helping people realize that they are not alone. Groups also provide ongoing support and a social context in which to learn more adaptive interpersonal skills.

Increasing Personal Power

Alternatively, Anderson (1994) and other sociologically minded therapists focused on increasing the codependents' personal power. Emphasis was placed on helping the codependent client understand the importance of changing the social and political institutions that created the problem.

Appreciating Women's Desire for Connectedness

Granello and Beamish (1998) urged therapists to support women's desire for connectedness. They encouraged therapists to recognize that women may not have developed the ability to value their own thoughts and feelings since much of their role consists of taking care of others. Women should be helped to define themselves in terms of their strengths rather than their weaknesses. These authors maintained that women can benefit by understanding their desire for connectedness. A woman's self-concept may be strengthened as her therapist assists her in framing this desire for connectedness as being a strength rather than a sign of immaturity or pathology.

Changing Relational Patterns

Cullen and Carr (1999), representative of a family systems perspective, suggested that a focus on the codependent individual is not as productive as a systems focus that examines interactional patterns. In fact, it is these relational patterns that are considered to maintain the psychological symptoms in the individual. Prest et al. (1998) maintained that family systems therapy is helpful in changing the dynamics and relationship dysfunction that contribute to codependency. In this process, family members are

encouraged to replace unhealthy patterns, such as fusion and intimidation, with skills for gaining individuation and intimacy.

The goal of family systems therapy is to help clients separate themselves from their enmeshed families allowing for more differentiated relationships with other significant people in their lives. This differentiation occurs through directed family-of-origin homework or through family therapy. Therapists of codependent clients need to build a supportive relationship with the client, recognizing the advantages and disadvantages of his/her care-taking tendencies. Wells et al. (1999) suggested that through the therapeutic relationship, clients may learn authentic intimacy, which they can generalize to other relationships beyond the therapy setting. In addition, Prest and Protinsky (1993) stated that clients need to learn how to balance emotional reactivity with rational decisions within the intergenerational family context. This balance may help to interrupt the transmission of identity and intimacy problems associated with codependency.

Scaturo et al. (2000) mentioned that it is important for family-systems-oriented therapy to address the codependent behavior by validating the individuals' good intentions. A role of the therapist is to assist codependents in finding new ways of being useful in the family, rather than depriving them of their helping role. It is important to help codependent individuals to distinguish between codependency and normal, nurturing behaviors.

Chapter Summary

Codependency has become a popular theme in self-help psychology. A concept once limited to the dysfunctional results of living with an alcoholic is now broadened and

applied to a number of interpersonal problems. As a result of this growing popularity, many clients make a self-diagnosis based on information learned through television talk shows, self-help psychology books, and the internet. At the price of overgeneralization, the popularity of codependency appears to have challenged many people to examine the basis of their identity and their ways of relating to others.

Confusion and debate surround the codependency construct in popular and professional literature alike. Some proponents have advocated that codependency is a valuable construct used to facilitate communication among professionals, help individuals understand and normalize their experiences, and provide an explanation for dysfunctional patterns of relating. Some considered codependency to be a personality style that warrants inclusion in the *DSM-IV-TR* (APA, 2000). Others insisted it is a social construct resulting from societal inequalities and socialized gender role. Opponents of the construct have contended that it lacks diagnostic discriminative validity. They considered codependency to be an overgeneralized buzzword used to stereotype clients. They warned that codependency has become big business, placing clients at risk for exploitation.

Although inconclusive, the literature appears to support codependency as a personality construct in which individuals share predictable behaviors and relational patterns. However, the literature seems to yield insufficient evidence to substantiate the recognition of codependency as a *DSM-IV-TR* (APA, 2000) personality disorder. It appears to lack discriminative diagnostic validity and any attempts made to operationalize this construct have lacked empirical support.

There is substantial evidence for the premise that codependency emerges out of a dysfunctional family of origin. Contrary to popular belief, this dysfunction is not limited to families characterized by abuse. This relational style may be a by-product of defenses used by children who developed in an emotionally restricted environment. The child learns that meeting the needs of others is a necessary part of earning others' love and approval. The individual turns to others for a sense of identity and worth, resulting in self-abandonment. Although these coping strategies may serve a purpose during childhood, they are maladaptive in adulthood.

The current literature does not support the popular belief that codependency is a dysfunction limited to women. Some confusion surrounding this issue may be attributed to the difference in the codependency profile between males and females. In fact, many empirical inquiries reveal no significant difference in prevalence between genders in the samples considered. While the conceptualization of codependency as a social construct may be remindful of the need for cultural sensitivity, empirical evidence is lacking to support the notion of codependency equating to a discriminative and pathologized female gender role or the direct result of societal oppression.

In considering the theories represented in the literature, family systems theory appears to be the predominant and most empirically supported theory present, offering detailed explanation for the codependent's patterns of relating. Within this theoretical framework, not only is the role of the family of origin highlighted in the development of codependency but consideration is given to possible implications for present and future relational dynamics within the family.

Support for the construct of codependency is found in family systems theory. Family systems theorists have identified many of the same principles of codependency using different terminology, such as Bowen's undifferentiated self and undifferentiated family ego mass. These principles have been in existence and operational for several decades and have provided the foundational premises in family systems theory as it is known today.

Codependency is about relational patterns and may be valuable in understanding family dynamics. The dysfunctional family of the codependent is characterized by loss of flexibility and adaptability. The codependent often communicates mixed messages to other family members as he/she desires closeness but fears intimacy. The marriage relationship of a codependent individual is typically characterized by anxiety and insecurity. As a result of this insecurity, codependents tend to be intensely jealous and possessive of their spouses' attention. Unsure of their ability to rely on their spouse as a source of security, they fear abandonment, have difficulty trusting, feel misunderstood, and question their worthiness to be loved.

The codependent parent is often emotionally unavailable for the child and has difficulty allowing a child to possess his/her own identity. A codependent's shame and self-hate are aimed toward the child whom he/she considers to be a mere extension of self. The codependent places unrealistic pressure on the child to be perfect. The child will continually set higher goals in an attempt to secure the approval and love of the codependent parent. Inability to reach these unrealistic goals leads the child to believe that he/she is a failure. In an attempt to feel less anxious, the child tries to gain control of others by doing for them, anticipating their thoughts, feelings, and needs. The needs of

the child are overlooked as the family members' energy is put into the many needs of the dysfunctional family system.

Unfortunately, therapeutic considerations are underrepresented in the literature, and those mentioned are not backed by empirical support. Recommendations include addressing misconceptions, developing self-esteem, increasing awareness, letting go of the need to control, and managing toxic shame. References are also made to healing the inner child, attending a 12-step support group, increasing interpersonal power, helping women appreciate their desire for connectedness, and changing relational patterns.

The professional literature contains a substantial amount of research using a codependency construct to describe the relational patterns of individuals in a dysfunctional family system or experiencing chemical dependency. Brief consideration is given to the prevalence of codependent traits among nursing students. However, inadequate consideration is given to how people with codependent tendencies may seek out a career in counseling to fulfill personal needs. Further research needs to be conducted regarding the validity of codependency as a personality style, the role codependent tendencies play in career choice, and the dynamics of codependency in a therapeutic relationship.

CHAPTER III

METHODOLOGY

Research Design

A two-group comparison was used to compare the incoming students' level of codependency with that of the exiting students. This comparison was conducted to determine what impact, if any, the current curriculum had on the students' level of codependency. No specific intervention was implemented to intentionally influence students' knowledge of codependency. However, portions of the MAC curriculum had been previously designed to increase students' self-awareness and educate students regarding healthy patterns of relating to clients in the counseling setting.

Because the exiting students progressed through 39 credit hours of the core curriculum to which the incoming students had not yet been exposed, it is possible that a secondary effect could have influenced the results of this study. The core curriculum included the following courses: CNS 602 The Counselor and Diversity, CNS 611 Legal Issues and Ethics, CNS 656 Research in Counseling, CNS 645 Developmental Issues, CNS 672 Psychopathology, CNS 636 Assessment and Testing, CNS 664 Career Counseling, CNS 621 Counseling Theory in a Multicultural Setting, CNS 622 Counseling Techniques in a Multicultural Setting, CNS 641 Group Process and Counseling, CNS 668, Consulting in the Helping Professions, CNS 650 Practicum in Counseling, and CNS 677 Capstone in Christian Counseling. Consistency of this

curriculum across all the SAU sites is maintained by including pre-packaged student coursework and encouraging instructors not to deviate from the prescribed curriculum.

Population

Spring Arbor University (SAU) is a Free Methodist University with a main campus located in Spring Arbor, Michigan. SAU has 14 satellite sites throughout the state of Michigan. A Master of Arts in Counseling (MAC) is offered on the main campus and at nine of the satellite sites, which include Battle Creek, Kalamazoo, Grand Rapids, Lansing, Flint, Gaylord, Lambertville, Dearborn, and Troy. Typically, students are adult learners in their mid-30s to early 40s.

To be admitted into the MAC program, prospective students are required to submit an application packet that contains a standard graduate application, a statement of intent, and two letters of reference. In addition, students must have a bachelor's degree from an accredited institution, must earn a minimum GPA of 3.0 in the last 2 years of their undergraduate program, must attend an interview with the graduate director and the program coordinator, and must demonstrate writing ability in an on-site writing exercise. Results of the application process are reviewed by an admissions committee.

Admitted students participate in the program as a cohort group. This group sequentially progresses through the program in a lock-step fashion over the course of 32 continuous months. All students attend an orientation night at their respective sites prior to beginning the coursework. After the completion of the core coursework (excluding six credits of electives that may be taken at anytime in the program), students participate in their internships for the final 8 months of the program.

For the purposes of this study, two groups of students were examined, incoming students and exiting students. Three inclusion criteria were used to identify participants in the incoming group and two inclusion criteria were used for the exiting group. For the incoming student group, the criteria included those students who entered the MAC program in the fall of 2005, who had not yet begun any graduate coursework related to the counseling field, and who were voluntarily participating in the study. For the exiting student group, the criteria included those students who were enrolled in their internships during the 2005-2006 school year and who voluntarily participated in the study. Transfer students were not included in the incoming group; however, they could have participated with the exiting group provided they met the criteria. Participants' anonymity was maintained throughout this study.

Instrument

The Codependency Assessment Tool (CODAT), developed by Hughes-Hammer et al. (1998b), is a 25-item multivariate tool designed to measure codependency in adults (Appendix A). These authors reported that the theoretical framework for the CODAT is based predominately on the work of Wegscheider-Cruse and Cruse (1990). Within this framework, codependency has three core symptoms: delusion, repression, and compulsion, along with three associated symptoms that include low self-worth, relationship problems, and medical problems.

Integrating the work of Wegscheider-Cruse and Cruse (1990) with the findings of other research described in the professional literature on codependency, Hughes-Hammer et al. (1998b) identified some prevalent themes. A combination of qualitative and quantitative methods was implemented to further explore these themes, resulting in the

development of an initial pool of 250 items believed to represent codependency. These 250 items were then reviewed by eight independent counselors and psychologists who were considered to be experts in the field of addictions. Based on their feedback, 70 items were omitted, leaving a total of 180 items. To assess content validity, these items were again submitted to the same eight experts who were asked to rank each item using a 4-point Likert scale to reflect item relevancy to the codependency construct. Items with a score of less than 3.5 were dropped, yielding a total of 153 remaining items. Next, the 153-item tool was given to 236 clients receiving inpatient or outpatient therapy. Finally, a factor analysis was conducted in which five factors were identified that explained 44.7% of the variance. Based on this factor analysis, the authors identified one main concept, Other Focus/Self-Neglect, and four accompanying secondary concepts, which they identified as Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues. These five areas now serve as the core areas of codependency that the CODAT attempts to measure.

Specifically, Other Focus/Self-Neglect is defined as the compulsion to help or control others through advice-giving or manipulation. Low Self-Worth assesses individuals' propensity for self-criticism, shame, self-blame, and humiliation. Hiding Self reflects the codependent individuals' tendency to falsify feelings by displaying positive emotions and denying negative ones. Medical Problems measures the individuals' tendency to be preoccupied with real or imagined somatic complaints. Finally, Family of Origin Issues is used to characterize individuals' current unhappiness as a result of growing up in families that were dysfunctional. Typically, these families lacked open communication and affective expression or they experienced abuse; hence, the

individuals learned codependent patterns of relating. After identifying these five key factors, the authors used the 153-item pool from which to select the top five items that best reflected each of the factors. This process resulted in a 25-item assessment instrument with five subscales.

Reliability: A Cronbach's alpha for the 25-item instrument was α =.91. Reliability for each subscale was as follows: Other Focus/Self-Neglect (α = .85), Low Self-Worth (α = .84), Family of Origin Issues (α = .81), Hiding Self (α = .80), and Medical Problems (α = .78).

Validity: Criterion validity was established by administering the CODAT to a control group of 38 professional women and a group of 21 women who were receiving outpatient therapy for codependency. Results indicated that codependent women scored significantly higher on each scale when compared to women in the control group ($p< 0.01$).

Procedure

I administered the CODAT to incoming students during the MAC orientation night. Specifically, students responded to the assessment approximately an hour and a half into the orientation, following presentations about American Psychological Association (APA) writing format and library resources. The CODAT was administered before a discussion regarding the MAC program and student expectations ensued.

Exiting students were assessed using the CODAT at one of the scheduled seminar nights mandated by the course CNS 680/682 Internship I & II. These seminars are scheduled near the completion of their program.

To ensure uniform delivery, I read standardized information about the study and assessment tool for both the incoming and the exiting groups (Appendix B). Students were given ample time to finish the assessment. Several steps ensured student anonymity. First, students sat so that they were unable to see classmates' response sheets. Second, students had cover sheets to place over their response sheets. Third, students used large envelopes to place completed response sheets in a box located at the back of the room. Students exited the room for break upon returning their packet. Students who did not wish to participate in the study turned in a blank response sheet using the procedure outlined above. This process prevented differentiating between students who chose to participate in this study and those who chose to abstain from this study. The response sheets did not contain any identifying information. I collected the content of the box and hand scored the response sheets for data analysis.

Research Questions and Null Hypotheses

Research Question 1: What is the level of codependency in master's-level counseling students?

Research Question 2: Is there a significant difference in level of codependency between incoming and exiting master's-level counseling students?

Null Hypothesis 1: There is no significant difference between incoming and exiting students on the CODAT composite score.

Null Hypothesis 2: There are no significant differences between incoming and exiting students on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Research Question 3: Is codependency in master's-level counseling students related to age, gender, or religious preference?

Null Hypothesis 3: There are no significant interaction effects between student status and age on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Null Hypothesis 4: There are no significant interaction effects between student status and gender on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Null Hypothesis 5: There are no significant interaction effects between student status and religious preference on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Methods of Analysis

Data analyses to answer the research questions and test the null hypotheses were conducted using an $\alpha = 0.05$ with the exception of those surrounding the core areas. For the core areas, groups were being compared on multiple variables so the potential for inflation of Type I error was present. To control for this error, a Bonferroni adjustment was made. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

To determine level of codependency, means were analyzed for the composite and core area CODAT scores and then applied to a four-level classification system used by Martsolf et al. (2000). An independent *t* test was conducted to compare the composite codependency score of the incoming students with that of the exiting

students. In addition, independent *t* tests were conducted to compare incoming and exiting students on the five CODAT core areas.

One-way ANOVAs were used to determine if there was a significant difference among the age groups on the CODAT composite score as well as on each of the core area scores. With regard to gender, independent *t* tests were used to see if there were significant differences between males and females on the CODAT composite score and the core area scores. One-way ANOVAs were used to examine CODAT composite and core area scores among the religious preference groups. Two-way ANOVAs were used to determine if any significant interaction effects were present between student status and each of the variables of age, gender, and religious preferences on the composite and core area scores.

CHAPTER IV

ANALYSIS OF DATA

The purpose of this study was to examine the level of codependency in master's-level counseling students and to determine if there was a significant difference in the level of codependency between incoming and exiting students. In addition, inquiry was made into whether or not these students' level of codependency was related to age, gender, or religious preference. This chapter contains a description of the sample, basic data, testing of the null hypotheses, and a summary of the findings. Unless otherwise indicated, statistical analysis was conducted using $\alpha = 0.05$.

Description of the Sample

The sample was comprised of students in Spring Arbor University's Master of Arts in Counseling Program. Of the 283 students eligible to participate in this study, six students were absent during the class session the questionnaire was administered, and two individuals opted not to participate. There was a total of 275 actual participants whose mean age was 36.54 (SD =10.03), ranging from 22 to 63 years of age. As outlined in the demographic summary in Table 1, there was more than four times the number of female students (82.5%) when compared to the number of male students (17.5%). The ethnicity of the group was predominately Caucasian (77.8%) followed by African American (18.2%), Hispanic (1.5%), and Other (1.8%).

Table 1

Frequencies of the Demographic Variables

Demographic variable	Incoming (n = 155)		Exiting (n = 120)		Total (N = 275)	
	n	%	*n*	%	*n*	%
Gender						
Females	133	85.8	94	78.3	227	82.5
Males	22	14.2	26	21.7	48	17.5
Total	155	100.0	120	100.0	275	100.0
Race						
Caucasian	124	80.0	90	75.0	214	77.8
African American	24	15.5	26	21.7	50	18.2
Asian	0	0.0	0	0.0	0	0.0
Hispanic	2	1.3	2	1.7	4	1.5
Other	3	1.9	2	1.7	5	1.8
Total	153	98.7	120	100.0	273	99.3
Religious Preference						
Protestant	99	63.9	74	61.7	173	62.9
Catholic	17	11.0	13	10.8	30	10.9
Other	34	21.9	30	25.0	64	23.3
Total	150	96.8	117	97.5	267	97.1
Practicing Religion						
Practicing	113	72.9	95	79.2	208	75.6
Non-practicing	26	16.8	12	10.0	38	13.8
Total	139	89.7	107	89.2	246	89.5
Martial Status						
Married	85	54.8	75	62.5	160	58.2
Single	48	31.0	29	24.2	77	28.0
Divorced	16	10.3	14	11.7	30	10.9
Separated	4	2.6	0	0.0	4	1.5
Widowed	2	1.3	2	1.7	4	1.5
Total	155	100.0	120	100.0	275	100.0
Number of Children						
0	57	36.8	42	35.0	99	36.0
1	26	16.8	19	15.8	45	16.4
2	40	25.8	29	24.2	69	25.1
3	16	10.3	21	17.5	37	13.5
4	9	5.8	5	4.2	14	5.1
5	5	3.2	1	0.8	6	2.2
6	0	0.0	2	1.7	2	0.7
7	0	0.0	1	0.8	1	0.4
8	2	1.3	0	0.0	2	0.7
Total	155	100.0	120	100.0	275	100.0

Table 1—*Continued.*

Demographic variable	Incoming (n = 155)		Exiting (n = 120)		Total (N = 275)	
	n	%	*n*	%	*n*	%
Educational Level						
Bachelor's	142	91.6	108	90.0	250	90.9
Master's	6	3.9	11	9.2	17	6.2
Attempted Unrelated Graduate	7	4.5	0	0.0	7	2.5
Doctorate	0	0.0	1	0.8	1	0.4
Attempted Related Graduate	0	0.0	0	0.0	0	0.0
Total	155	100.0	120	100.0	275	100.0
Occupational Pathway						
Human Services	105	67.7	74	61.7	179	65.1
Business/Management	21	13.5	13	10.8	34	12.4
Other: Student, None	4	2.6	20	16.7	24	8.7
Health	11	7.1	7	5.8	18	6.5
Engineering/Technology	6	3.9	0	0.0	6	2.2
Arts/Communication	2	1.3	1	0.8	3	1.1
Total	149	96.1	115	95.8	264	96.0
Employment						
Employed	135	87.1	95	79.2	230	83.6
Unemployed	19	12.3	24	20.0	43	15.6
Total	154	99.4	119	99.2	273	99.3
Number of Hospitalizations						
0	145	93.5	113	94.2	258	93.8
1	3	1.9	4	3.3	7	2.5
2	4	2.6	3	2.5	7	2.5
6	1	0.6	0	0.0	1	0.4
8	2	1.3	0	0.0	2	0.7
Total	155	100.0	120	100.0	275	100.0
Drugs: Self						
No Substance Abuse	138	89.0	108	90.0	246	89.5
Substance Abuse	17	11.0	11	9.2	28	10.2
Total	155	100.0	119	99.2	274	99.6
Drugs: Spouse/Significant Other						
No Substance Abuse	127	81.9	95	79.2	222	80.7
Substance Abuse	27	17.4	22	18.3	49	17.8
Total	154	99.4	117	97.5	271	98.5
Drugs: Parent						
No Substance Abuse	119	76.8	87	72.5	206	74.9
Substance Abuse	36	23.2	32	26.7	68	24.7
Total	155	100.0	119	99.2	274	99.6

Note. Due to missing values, percentages may not equal 100%.

With regard to religious preference, almost all of the participants identified themselves as being affiliated with a Christian religion. A minority of individuals (5.1%) considered their religious affiliation to be non-Christian. Regardless of preference, the majority of participants reported currently participating in their religion (75.6%).

Four demographic variables were considered in relation to family: marital status, number of children, past or present substance abuse by parents, and past or present substance abuse by spouse/significant other. One hundred and sixty (58.2%) individuals were currently married, 77 (28.0%) single, 30 (10.9%) divorced, 4 (1.5%) separated, and 4 (1.5%) widowed. The reported number of children ranged from zero to eight. Ninety-nine (36%) participants reported having no children whereas 11 (7.3%) individuals indicated they had five or more children. Additionally, 49 (17.8%) of the participants indicated their spouse/significant other has experienced substance abuse problems, and 68 (24.7%) students reported having a parent who has experienced problems with substance abuse.

Educational level and career pathway were also examined. The highest completed educational level of the group was predominately bachelor's level (90.9%) although 18 students (6.6%) indicated they already had earned a master's or doctorate degree. The majority of participants identified their career pathway to be Human Services (65.1%) followed by the career pathway of Business, Management, Marketing, and Technology (12.4%). Of the 275 participants, 230 (83.6%) stated they were currently employed.

Consideration given to students' personal mental health yielded that the majority of students denied any previous mental health hospitalizations (93.8%) or problems with substance abuse (89.5%). Seventeen participants (6.1%) reported previous

hospitalizations due to mental health concerns. These hospitalizations ranged from one to eight times and were attributed to problems with major depression, suicide attempts, anxiety, eating disorders, or bipolar illness with psychotic features. Twenty-eight individuals (10.2%) reported a past or present struggle with substance abuse.

In summary, the participants in this investigation were predominately Caucasian females, mid-30s, and married with no children. Their religious preference was Protestant, which they regularly practiced. They had completed a bachelor's degree and were currently employed in the human services field. They have never been hospitalized for mental health-related issues and denied any problems related to substance abuse on the part of self, spouse, or parent.

The target group was divided into two groups based on their status in the Master of Arts in Counseling Program: Incoming (56%) and Exiting (44%). As illustrated in Table 1, the two subgroups appear very similar on almost all of the demographic variables. The most noticeable exception to this similarity was the number of previous mental health hospitalizations. Members of the incoming group reported a greater number of hospitalizations than those of the exiting group. For example, one member of the incoming group reported six hospitalizations, and two other members each reported eight hospitalizations. In contrast, the highest number of hospitalizations reported by a single individual of the exiting group was two.

The Research Questions

Research Question 1

Research Question 1: What is the level of codependency among master's-level counseling students?

Level of Codependency Based on the Composite Score

Participants were administered the Codependency Assessment Tool (Hughes-Hammer et al., 1998b) with possible score ranges from 25 to 125. The 275 individuals who responded to the questionnaire yielded a mean score of 48.99 (*SD* =12.04) with scores ranging from 26.0 to 92.0. In the work of Martsolf, Sedlak, and Doheny (2000), individuals were classified among four levels based on the CODAT score: Minimal (25 to 50), Mild to Moderate (51 to 75), Moderate (76 to 100), and Severe (101 to 125).

Application of this classification system was applied to the present investigation. In terms of the overall population, 158 students (57.5%) scored in the Minimal range, 107 students (38.9%) scored in the Mild to Moderate range, and 10 students (3.6%) in the Moderate range. No students scored in the Severe range. This overall classification is representative of both the incoming and exiting groups of students (Table 2).

Table 2

Level of Codependency in Master's-Level Counseling Students

Range	*n*	%	*M*	*SD*
Minimal	158	57.5	40.83	5.33
Mild-Moderate	107	38.9	57.92	6.67
Moderate	10	3.6	82.40	6.08
Severe	0	0.0	0.00	0.00
Total	275	100.0	49.00	12.04

Level of Codependency Based on the Core Areas

In addition to providing a composite score, the CODAT assessed five core areas: Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues. Individuals responded to statements in each of these core areas using a 5- point scale with 1 representing *Rarely or Never* and 5 signifying *Most of the Time.* Scaling the score ranges used on the composite codependency score provided the ranges used to assess the level of codependency on each of the core areas: None (1 to 5), Minimal (6 to 10), Mild to Moderate (11 to 15), Moderate (16 to 20), and Severe (21 to 25). Respondents indicated the greatest tendencies toward codependency in the area of Family of Origin Issues (M = 13.39, SD = 5.46), with a mean score that reflected a Mild to Moderate level of codependency (Table 3). Also, in the core area Hiding Self (M =10.75, SD = 3.55) participants yielded a mean score that was consistent with a Mild to Moderate level of codependency. The core areas Other Focus/Self-Neglect (M = 9.64, SD = 3.24), Low Self-Worth (M = 8.15, SD =3.40), and Medical Problems (M =7.06, SD = 2.85) were all in the minimal range.

Table 3

Descriptive Statistics for the CODAT Core Areas

Core Area	Range	*M*	*SD*
Family of Origin Issues	Mild – Moderate	13.39	5.46
Hiding Self	Mild – Moderate	10.75	3.55
Other Focus/Self-Neglect	Minimal	9.64	3.24
Low Self-Worth	Minimal	8.15	3.40
Medical Problems	Minimal	7.06	2.85

Table 4 provides a rank order of the questions associated with each core area. Family of Origin Issues contained the three statements that had the highest means overall. The reversed scored item, item 20, represented the highest mean ($M = 3.23$, $SD = 1.43$) followed by item 15 ($M = 2.94$, $SD = 1.43$) and item 23 ($M = 2.54$, $SD = 1.32$), all of which dealt with the openness of communication in the participants' family of origin. Students perceived that communication in their family of origin was not as open as they would have liked.

In the core area Hiding Self, item 14 ($M = 2.43$, $SD = 1.10$), which suggested that students tended to keep their emotions tightly controlled, and item 11 ($M = 2.35$, $SD = 1.00$), which indicated that students perceived they had a "good front," had the two highest means within this core area. Item 13 ($M = 1.78$, $SD = 0.85$) had the lowest core mean and reflected students' perceived level of hiding self to keep from being known by others.

In the core area Other Focus/Self-Neglect, individuals had the strongest response to items 8 ($M = 2.41$, $SD = 1.16$) and 1 ($M = 2.26$, $SD = 1.11$), addressing the need to help others solve problems and giving unwanted advice. Within this core area, students reported their attempts to try to control others using manipulation were minimal ($M = 1.34$, $SD = 0.59$).

In the core area Low Self-Worth, students reported that they tended to blame themselves for everything (item 21, $M = 2.08$, $SD = 1.11$). Participants scored lowest of all the core areas on item 25 ($M = 1.18$, $SD = 0.54$), which was designed to assess the level of self-hate suggesting that individuals had a fairly positive self-image.

Table 4

Descriptive Statistics for Items in the Core Areas

Item	Paraphrased Statement	*N*	*M*	*SD*
	Family of Origin Issues			
20R	Family expressed feelings/affections openly	274	3.23	1.43
15	Family didn't talk openly about problems	273	2.94	1.43
23	Unhappy about way family communicated	275	2.54	1.32
22	Unhappy about way family coped with problems	275	2.41	1.31
19	Family was troubled, unfeeling, or chemical dep.	275	2.27	1.46
	Hiding Self			
14	Keep emotions tightly controlled	275	2.43	1.10
11	Keep feelings to self/good front	275	2.35	1.00
10	Happy face when sad or angry	275	2.21	1.02
18	Push painful thoughts out of awareness	275	1.97	0.89
13	Hide self so no one really knows me	275	1.78	0.85
	Other Focus/Self-Neglect			
8	Compelled to help others solve problems	274	2.41	1.16
1	Compelled to help by unwanted advice	275	2.26	1.11
2	Try to control events and others' behavior	275	2.08	0.98
3	Afraid to let others be who they are	272	1.55	0.83
5	Try to control others with manipulation	275	1.34	0.59
	Low Self-Worth			
21	Blame self for everything	274	2.08	1.11
17	Pick on myself for everything: look, act	275	1.94	1.04
24	Feel humiliated or embarrassed	275	1.51	0.08
4	Feel ashamed of who I am	273	1.44	0.69
25	Hate myself	275	1.18	0.54
	Medical Problems			
12	Feel ill and run down	274	1.61	0.82
16	Have stomach, bowel, or bladder trouble	274	1.51	1.00
9	General health poor compared to others	275	1.33	0.78
6	Worry about having stomach/liver trouble	275	1.33	0.67
7	Preoccupied that body is failing	275	1.29	0.63

In the core area Medical Problems, the item with the strongest response was item 12 ($M = 1.61$, $SD = 0.82$), which stated that individuals felt ill and run down. Individuals only minimally reported being preoccupied that their body was failing (item 7; $M = 1.29$, $SD = 0.63$).

In summary, respondents' CODAT mean score (48.99) placed them at the Minimal level of codependency. The majority of students scored in the Minimal range, with some students scoring in the Mild to Moderate range and the Moderate range. There were no students who scored in the Severe range. Of the five core areas, students scored in the Mild to Moderate range in the areas of Family of Origin Issues and Hiding Self. Mean scores in the areas of Other Focus/Self-Neglect, Low Self-Worth, and Medical Problems were in the Minimal range. Collectively, respondents scored highest on items from the core area Family of Origin Issues, which dealt with the openness of communication, indicating that the communication style in their family of origin was not as open as they would have liked. Participants scored lowest on an item in the core area Low Self-Worth, which was designed to measure self-hate, suggesting that they had a fairly positive self-image.

Research Question 2

Research Question 2: Is there a significant difference in the level of codependency between incoming and exiting master's-level counseling students?

Level of Codependency Based on the Composite Score

Null Hypothesis 1: There is no significant difference between incoming and exiting students on the CODAT composite score.

An independent *t* test was conducted to compare the composite codependency score of the incoming students ($M = 49.83$, $SD = 11.98$) with that of the exiting students ($M = 47.92$, $SD = 12.08$). There was no significant difference between the incoming and exiting students with regard to the composite codependency score ($p = 0.192$) (Table 5). Therefore, the null hypothesis was retained.

Table 5

Descriptive Statistics and t *Test for Student Status on the Composite CODAT Score*

Student Status	*n*	*M*	*SD*	*t*	*df*	*p*
Incoming	155	49.83	11.98	1.307	273	0.192
Exiting	120	47.92	12.08			
Overall	275	48.99	12.04			

Level of Codependency Based on the Core Areas

Null Hypothesis 2: There are no significant differences between incoming and exiting students on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Each of the five core areas was examined to determine if group differences existed between the incoming and the exiting students (Table 6). Because groups were being compared on multiple variables, the potential for inflation of Type I error was present. To control for this error, a Bonferroni adjustment was made. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

Table 6

Descriptive Statistics and t *Test for Student Status on the Core Areas*

Variable	Incoming (n = 155)		Exiting (n = 120)				
	M	*SD*	*M*	*SD*	*t*	*df*	*p*
Other Focus/Self-Neglect	10.03	3.38	9.13	2.98	2.299	273	0.022
Low Self-Worth	8.31	3.14	7.95	3.71	0.890	273	0.374
Hiding Self	10.86	3.67	10.60	3.41	0.597	273	0.551
Medical Problems	6.87	2.69	7.31	3.04	1.283	273	0.201
Family of Origin Issues	13.76	5.57	12.92	5.22	1.261	273	0.208

There were no significant differences found between incoming and exiting students on the CODAT core areas of Other Focus/Self-Neglect ($p = 0.022$), Low Self-Worth ($p = 0.374$), Hiding Self ($p = 0.551$), Medical Problems ($p = 0.201$), or Family of Origin Issues ($p = 0.208$). Therefore, the null hypothesis was retained.

In summary, there was no significant difference on the composite CODAT score between incoming and exiting counseling students. Additionally, there were no significant differences between incoming and exiting students on the core areas Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, or Family of Origin Issues.

Research Question 3

Research Question 3: Is codependency in master's-level counseling students related to age, gender, or religious preference?

Age

As part of the demographic questionnaire on the CODAT, individuals were asked an open-ended question regarding their age. Analysis of the ages given by the respondents revealed an obvious distribution pattern that was used to group the data. Individuals were classified into the age ranges 22 to 27 (61), 28 to 34 (72), 35 to 44 (66), and 45 to 63 (73).

Age on the composite CODAT score

A one-way ANOVA was used to determine if a significant difference in the composite codependency score on the CODAT was present among respondents in the age

groups 22 to 27, 28 to 34, 35 to 44, and 45 to 63. As illustrated in Table 7, there was no significant difference ($p = 0.815$) in the composite score among the 22- to 27-year-olds ($M = 48.40$, $SD = 12.94$), 28- to 34-year-olds ($M = 49.42$, $SD = 12.95$), 35- to 44-year-olds ($M = 48.17$, $SD = 9.42$), and 45- to 63-year-olds ($M = 49.91$, $SD = 12.81$).

Table 7

Descriptive Statistics and One-Way ANOVA for Age on the Composite CODAT Score

Age	*n*	*M*	*SD*
22 – 27	61	48.40	12.94
28 – 34	72	49.42	12.95
35 – 44	66	48.17	9.42
45 – 63	73	49.91	12.81
Total	272	49.02	12.10

Source	*SS*	*df*	*MS*	*F*	*p*
Between Groups	139.254	3	46.420	0.315	0.815
Within Groups	39534.005	268	147.515		
Total	39673.258	271			

Age on the CODAT core areas

Table 8 contains the descriptive statistics for the age groups on each of the five core areas. A one-way ANOVA was conducted for each of the core areas to determine if significant differences among respondents in the age groups 22 to 27, 28 to 34, 35 to 44, and 45 to 63 were present (Table 9). Because groups were being compared on multiple variables, the potential for inflation of Type I error was present. To control for this error, a Bonferroni adjustment was made. As a result, analyses of these core areas were

Table 8

Descriptive Statistics for Age on the Core Areas

Variable	Age	*n*	*M*	*SD*
Other Focus/Self-Neglect	22 – 27	61	10.57	3.56
	28 – 34	72	9.42	2.82
	35 – 44	66	9.54	2.98
	45 – 63	73	9.31	3.46
	Total	272	9.68	3.23
Low Self-Worth	22 – 27	61	8.58	3.68
	28 – 34	72	8.53	4.04
	35 – 44	66	7.38	2.17
	45 – 63	73	8.10	3.37
	Total	272	8.15	3.41
Hiding Self	22 – 27	61	10.79	3.91
	28 – 34	72	11.10	3.40
	35 – 44	66	10.41	3.31
	45 – 63	73	10.67	3.64
	Total	272	10.75	3.55
Medical Problems	22 – 27	61	6.33	1.86
	28 – 34	72	7.44	3.28
	35 – 44	66	6.86	2.87
	45 – 63	73	7.49	3.01
	Total	272	7.06	2.86
Family of Origin Issues	22 – 27	61	12.13	5.75
	28 – 34	72	12.93	5.14
	35 – 44	66	13.98	5.09
	45 – 63	73	14.34	5.67
	Total	272	13.39	5.45

Table 9

One-Way ANOVAs for Age on the Core Areas

Variable	Source	*SS*	*df*	*MS*	*F*	*p*
Other Focus/Self-Neglect	Between Groups	65.122	3	21.707	2.107	0.100
	Within Groups	2761.071	268	10.303		
	Total	2826.193	271			
Low Self-Worth	Between Groups	61.283	3	20.428	1.767	0.154
	Within Groups	3097.442	268	11.558		
	Total	3158.725	271			
Hiding Self	Between Groups	16.883	3	5.628	0.443	0.722
	Within Groups	3404.613	268	12.704		
	Total	3421.496	271			
Medical Problems	Between Groups	59.234	3	19.745	2.452	0.064
	Within Groups	2158.205	268	8.053		
	Total	2217.439	271			
Family of Origin Issues	Between Groups	200.733	3	66.911	2.281	0.080
	Within Groups	7861.417	268	29.334		
	Total	8062.150	271			

Note. $p \leq 0.01$.

conducted using a significance level of 0.01 rather than 0.05. There were no significant differences among age groups on the CODAT core areas of Other Focus/Self-Neglect ($p = 0.100$), Low Self-Worth ($p = 0.154$), Hiding Self ($p= 0.722$), Medical Problems ($p = 0.064$), and Family of Origin Issues ($p = 0.080$).

Age and student status on the composite CODAT score

A two-way ANOVA was used to examine if an interaction effect was present between student status and age on the participants' composite score (Table 10). There

Table 10

Descriptive Statistics, Two-Way ANOVA, and Test of Simple Effects for Age and Student Status on the Composite CODAT Score

Student Status	Age	*n*	*M*	*SD*
Incoming (*n*=155)	22 – 27	44	51.40	12.96
	28 – 34	39	49.13	12.44
	35 – 44	36	47.00	8.71
	45 – 63	35	51.50	13.10
	Total	154	49.82	12.02
Exiting (*n* = 120)	22 – 27	17	40.65	9.39
	28 – 34	33	49.77	13.71
	35 – 44	30	49.58	10.19
	45 – 63	38	48.44	12.52
	Total	118	47.98	12.18
Overall (*N* = 275)	22 – 27	61	48.40	12.94
	28 – 34	72	49.42	12.95
	35 – 44	66	48.17	9.42
	45 – 63	73	49.91	12.81
	Total	272	49.02	12.10

Source	*SS*	*df*	*MS*	*F*	*p*
Group	442.895	1	442.895	3.091	0.080
Age	518.995	3	172.998	1.207	0.307
Group*Age	1428.625	3	476.208	3.323	0.020*
Error	37827.953	264	143.288		
Total	693306.929	272			
Corrected Total	39673.258	271			

Table 10—*Continued.*

Test of Simple Effects

Source	*SS*	*df*	*MS*	*F*
GROUP				
Age at Group1 (Incoming)	513.89	3	171.30	1.20
Age at Group 2 (Exiting)	1104.93	3	368.31	2.57*
AGE	1418.23	1	1418.23	9.89
Group at Age 1	7.38	1	7.38	0.17
Group at Age 2	109.12	1	109.12	0.76
Group at Age 3	171.31	1	171.31	1.20
Group at Age 4				
Error	37827.95	264	143.29	

*$p \leq 0.05$.

was a significant interaction effect between student status and age with regard to participants' composite codependency scores ($p = 0.020$). The effect of student status on codependency is dependent on the respondents' age.

A Test of Simple Effects was conducted to analyze group differences of one independent variable at each level of the other independent variable. Participants in the age range 22 to 27 of the incoming group ($M = 51.40$, $SD = 12.96$) scored significantly higher on the CODAT composite score than participants in this age range of the exiting group ($M = 40.65$, $SD = 9.39$). No other group differences were found.

Age and student status on the CODAT core areas

Null Hypothesis 3: There are no significant interaction effects between student status and age on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Because the groups were being compared on multiple variables, to control for Type I error a Bonferroni adjustment was made. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

Age and student status on Other Focus/Self-Neglect. As outlined in Table 11, a significant interaction effect was not found to exist between student status and age on the CODAT core area of Other Focus/Self-Neglect ($p = 0.076$). A main effect was not present with regard to either age ($p = 0.639$) or student status ($p = 0.035$) on Other-Focus/Self-Neglect.

Age and student status on Low Self-Worth. A significant interaction effect was found to exist between student status and age on the CODAT core area Low Self-Worth ($p = 0.009$) (Table 12). A Test of Simple Effects was conducted to identify group differences. For the exiting students, individuals in the 22 to 27 age range ($M = 6.53$, $SD = 2.18$) scored significantly lower than the individuals in the 28 to 34 age range ($M = 9.29$, $SD = 5.04$). Individuals in the 22 to 27 age range reported more positive self-worth when compared to individuals in the 28 to 34 age range. There was no significant age group difference found for the incoming students. Within the 22 to 27 age group, incoming students ($M = 9.37$, $SD = 3.85$) scored significantly higher on Low Self-Worth

Table 11

Descriptive Statistics and Two-Way ANOVA for Age and Student Status on Other Focus/Self-Neglect

Student Status	Age	*n*	*M*	*SD*
Incoming (*n*=155)	22 – 27	44	11.25	3.63
	28 – 34	39	9.72	2.93
	35 – 44	36	9.22	3.03
	45 – 63	35	9.83	3.55
	Total	154	10.07	3.37
Exiting (*n* = 120)	22 – 27	17	8.82	2.74
	28 – 34	33	9.06	2.69
	35 – 44	30	9.92	2.92
	45 – 63	38	8.83	3.34
	Total	118	9.17	2.98
Overall (*N* = 275)	22 – 27	61	10.57	3.56
	28 – 34	72	9.42	2.82
	35 – 44	66	9.54	2.98
	45 – 63	73	9.31	3.46
	Total	272	9.68	3.22

Source	*SS*	*df*	*MS*	*F*	*p*
Group	45.201	1	45.201	4.494	0.035
Age	17.038	3	5.679	0.565	0.639
Group*Age	69.947	3	23.316	2.318	0.076
Error	2655.104	264	10.057		
Total	28295.744	272			
Corrected Total	2826.193	271			

Note. $p \leq 0.01$.

Table 12

Descriptive Statistics, Two-Way ANOVA, and Test of Simple Effects for Age and Student Status on Low Self-Worth

Student Status	Age	*n*	*M*	*SD*
Incoming ($n = 155$)	22 – 27	44	9.37	3.85
	28 – 34	39	7.89	2.88
	35 – 44	36	7.42	1.93
	45 – 63	35	8.31	3.20
	Total	154	8.30	3.15
Exiting ($n = 120$)	22 – 27	17	6.53	2.18
	28 – 34	33	9.29	5.04
	35 – 44	30	7.33	2.47
	45 – 63	38	7.89	3.55
	Total	118	7.94	3.74
Overall ($N = 275$)	22 – 27	61	8.58	3.68
	28 – 34	72	8.54	4.04
	35 – 44	66	7.38	2.71
	45 – 63	73	8.10	3.37
	Total	272	8.15	3.41

Source	*SS*	*df*	*MS*	*F*	*p*
Group	15.166	1	15.166	1.352	0.246
Age	51.251	3	17.084	1.523	0.209
Group*Age	131.354	3	43.785	3.905	0.009*
Error	2960.451	264	11.214		
Total	21211.946	272			
Corrected Total	3158.725	271			

Table 12—*Continued.*

Test of Simple Effects

Source	*SS*	*df*	*MS*	*F*
GROUP				
Age at Group1 (Incoming)	84.99	3	28.33	2.53
Age at Group 2 (Exiting)	104.73	3	34.91	3.11*
AGE	99.20	1	99.20	8.85*
Group at Age 1	34.47	1	34.47	3.07
Group at Age 2	0.12	1	0.12	0.01
Group at Age 3	3.21	1	3.21	0.29
Group at Age 4				
Error	2960.45	264	11.21	

*$p \leq 0.01$.

when compared to the exiting students ($M = 6.53$, $SD = 2.18$). There was no other significant group difference found between the incoming and exiting students.

Age and student status on Hiding Self. As depicted in Table 13, there was no significant interaction effect between student status and age on the core area Hiding Self ($p = 0.476$). In addition, there was not a main effect present with regard to either age ($p = 0.705$) or student status ($p = 0.563$) on the variable Hiding Self. Students reported that any perceived need to hide their true selves was not dependent on their status in the MAC program or their age.

Age and student status on Medical Problems. As illustrated in Table 14, a significant interaction effect was not found to exist between student status and age on the

Table 13

Descriptive Statistics and Two-Way ANOVA for Age and Student Status on Hiding Self

Student Status	Age	*n*	*M*	*SD*
Incoming ($n = 155$)	22 – 27	44	11.16	3.92
	28 – 34	39	11.08	3.46
	35 – 44	36	10.08	3.45
	45 – 63	35	10.91	3.79
	Total	154	10.83	3.66
Exiting ($n = 120$)	22 – 27	17	9.82	3.83
	28 – 34	33	11.12	3.39
	35 – 44	30	10.80	3.14
	45 – 63	38	10.45	3.53
	Total	118	10.64	3.42
Overall ($N = 275$)	22 – 27	61	10.79	3.91
	28 – 34	72	11.10	3.40
	35 – 44	66	10.41	3.31
	45 – 63	73	10.67	3.64
	Total	272	10.75	3.55

Source	*SS*	*df*	*MS*	*F*	*p*
Group	4.279	1	4.279	0.335	0.563
Age	17.918	3	5.973	0.468	0.705
Group*Age	31.922	3	10.641	0.833	0.476
Error	3370.329	264	12.766		
Total	34833.000	272			
Corrected Total	3421.496	271			

Note. $p \leq 0.01$.

Table 14

Descriptive Statistics and Two-Way ANOVA for Age and Student Status on Medical Problems

Student Status	Age	*n*	*M*	*SD*
Incoming (*n* =155)	22 – 27	44	6.59	2.03
	28 – 34	39	7.38	3.65
	35 – 44	36	6.19	1.77
	45 – 63	35	7.27	2.87
	Total	154	6.85	2.69
Exiting (*n* = 120)	22 – 27	17	5.65	1.11
	28 – 34	33	7.52	2.83
	35 – 44	30	7.67	3.67
	45 – 63	38	7.68	3.15
	Total	118	7.34	3.06
Overall (*N* = 275)	22 – 27	61	6.33	1.86
	28 – 34	72	7.44	3.28
	35 – 44	66	6.86	2.87
	45 – 63	73	7.49	3.01
	Total	272	7.06	2.86

Source	*SS*	*df*	*MS*	*F*	*p*
Group	4.505	1	4.505	0.564	0.453
Age	68.158	3	22.719	2.845	0.038
Group*Age	42.060	3	14.020	1.755	0.156
Error	2108.450	264	7.987		
Total	15793.060	272			
Corrected Total	2217.439	271			

Note. $p \leq 0.01$.

core area Medical Problems ($p = 0.156$). A main effect was not present for either student status ($p = 0.453$) or age ($p = 0.038$) on Medical Problems.

Age and student status on Family of Origin Issues. As detailed in Table 15, a significant interaction effect was not found to exist between student status and age on the CODAT core area Family of Origin Issues ($p = 0.414$). A main effect was not found to be present on either student status ($p = 0.053$) or age ($p = 0.078$) with regard to Family of Origin Issues. Students' level of satisfaction with the openness, communication style, and coping strategies of their families was not dependent on their status in the program or their age.

In summary, there was a significant interaction effect between student status and age with regard to participants' composite score on the CODAT. Participants in the age range 22 to 27 of the incoming group scored significantly higher on the CODAT composite score than participants in this age range of the exiting group. A significant interaction effect was not found to exist between student status and age on the CODAT core areas Other Focus/Self-Neglect, Hiding Self, Medical Problems, or Family of Origin Issues. However, a significant interaction effect was present between student status and age on the core area Low Self-Worth ($p = 0.009$). Therefore, the null hypothesis was rejected.

Gender

Gender on the CODAT composite score

An independent *t* test (Table 16) was used to determine if a significant difference in the composite codependency score was present between female respondents and male

Table 15

Descriptive Statistics and Two-Way ANOVA for Age and Student Status on Family of Origin Issues

Student Status	Age	*n*	*M*	*SD*
Incoming (*N*=155)	22 – 27	44	13.03	5.76
	28 – 34	39	13.05	5.23
	35 – 44	36	14.08	5.36
	45 – 63	35	15.17	5.92
	Total	154	13.77	5.59
Exiting (*N* = 120)	22 – 27	17	9.82	5.16
	28 – 34	33	12.79	5.12
	35 – 44	30	13.86	4.83
	45 – 63	38	13.58	5.40
	Total	118	13.58	5.40
Overall (*N* = 275)	22 – 27	61	12.13	5.75
	28 – 34	72	12.93	5.14
	35 – 44	66	13.98	5.09
	45 – 63	73	14.34	5.67
	Total	272	13.39	5.45

Source	*SS*	*df*	*MS*	*F*	*p*
Group	109.861	1	109.861	3.773	0.053
Age	296.528	3	98.846	3.394	0.078
Group*Age	83.543	3	27.848	0.956	0.414
Error	7687.296	264	29.119		
Total	56803.603	272			
Corrected Total	8062.150	271			

Note. $p \leq 0.01$.

Table 16

Descriptive Statistics and t *Test for Gender on the Composite CODAT Score*

Gender	*n*	*M*	*SD*	*t*	*df*	*p*
Females	227	48.96	12.34	0.096	273	0.923
Males	48	49.15	10.63			
Total	275	49.00	12.04			

respondents. There was no significant difference between the composite score of the females ($M = 48.96$, $SD = 12.34$) when compared to the composite score of the males ($M = 49.15$, $SD = 10.63$).

Gender on the CODAT core areas

An independent *t* test was conducted for each of the cores areas to determine if significant group differences existed between males and females (Table 17). Since groups were being compared on multiple variables, a Bonferroni adjustment was made to control for Type I error. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

There was a significant difference between males ($M = 11.94$, $SD = 3.11$) and females ($M = 10.49$, $SD = 3.59$) on the core area Hiding Self ($\rho = 0.010$). Males reported a greater tendency to hide their true selves when compared to females. There were no significant differences on the CODAT core areas of Other Focus/Self-Neglect ($p = 0.686$), Low Self-Worth ($p = 0.988$), Medical Problems ($p = 0.698$), and Family of Origin Issues ($p = 0.137$) with regard to gender.

Table 17

Descriptive Statistics for Gender on the Core Areas

Core Area	Gender	*n*	*M*	*SD*	*t*	*df*	*p*
Other Focus/Self-Neglect	Females	227	9.60	3.30	0.405	273	0.686
	Males	48	9.81	2.92			
	Total	275	9.64	3.24			
Low Self-Worth	Females	227	8.15	3.45	0.015	273	0.988
	Males	48	8.15	3.16			
	Total	275	8.15	3.40			
Hiding Self	Females	227	10.49	3.59	2.588	273	0.010*
	Males	48	11.94	3.11			
	Total	275	10.75	3.55			
Medical Problems	Females	227	7.09	2.92	0.389	273	0.698
	Males	48	6.92	2.50			
	Total	275	7.06	2.85			
Family of Origin Issues	Females	227	13.62	5.56	1.492	273	0.137
	Males	48	12.33	4.66			
	Total	275	13.39	5.43			

*$p \leq 0.01$.

Gender and student status on the composite CODAT score

A two-way analysis of variance (ANOVA) revealed that a significant interaction was not found to exist between student status and gender ($p = 0.744$) on the composite codependency score. The performance of the incoming and exiting students on the composite score did not depend on whether the student was male or female. Also, there

were no significant differences found between incoming and exiting students ($p = 0.426$) or between males and females ($p = 0.832$) on the overall level of codependency (Table 18).

Table 18

Descriptive Statistics and Two-Way ANOVA for Gender and Student Status on the Composite CODAT Score

Gender	Group	*n*	*M*	*SD*
Females	Incoming	133	49.64	8.90
	Exiting	94	48.73	12.06
	Overall	227	49.15	10.63
Males	Incoming	22	49.86	12.44
	Exiting	26	47.69	12.14
	Overall	48	48.96	12.34
Total	Incoming	155	49.83	11.98
	Exiting	120	47.92	12.08
	Overall	275	49.00	12.04

Source	*SS*	*df*	*MS*	*F*	*p*
Gender	6.536	1	6.536	0.045	0.832
Group	92.535	1	92.535	0.636	0.426
Gender*Group	15.606	1	15.606	0.107	0.744
Error	39452.631	271	145.582		
Total	699824.829	275			
Corrected Total	39722.552	274			

Gender and student status on
the CODAT core areas

Null Hypothesis 4: There are no significant interaction effects between student status and gender on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Because the groups were being compared on multiple variables, to control for Type I error a Bonferroni adjustment was made. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

Gender and student status on Other Focus/Self-Neglect. As outlined in Table 19, a significant interaction effect was not found to exist between student status and gender on the codependency variable Other Focus/Self-Neglect ($p = 0.932$). Also, it was found that a significant main effect did not exist in either student status ($p = 0.083$) or gender ($p = 0.529$) on the core area of Other Focus/Self-Neglect. Participants' tendency to focus on the needs of others was not dependent on the interaction of their status within the program and their gender.

Gender and student status on Low Self-Worth. A significant interaction effect was not found to exist between student status and gender on the CODAT core area of Low Self-Worth ($p = 0.824$; Table 20). A main effect did not exist between student status and Low Self-Worth ($p = 0.411$) or gender and Low Self-Worth ($p = 0.936$). Students' reported view of self was not dependent on the interaction of their status in the program and their gender.

Table 19

Descriptive Statistics and Two-Way ANOVA for Gender and Student Status on Other Focus/Self-Neglect

Gender	Group	*n*	*M*	*SD*
Females	Incoming	133	9.99	3.41
	Exiting	94	9.05	3.09
	Overall	227	9.60	3.30
Males	Incoming	22	10.27	3.30
	Exiting	26	9.42	2.56
	Overall	48	9.81	2.92
Total	Incoming	155	10.03	3.38
	Exiting	120	9.13	2.98
	Overall	275	9.64	3.24

Source	*SS*	*df*	*MS*	*F*	*p*
Gender	4.132	1	4.132	0.398	0.529
Group	31.307	1	31.307	3.018	0.083
Gender*Group	0.076	1	0.076	0.007	0.932
Error	2811.244	271	10.374		
Total	28426.744	275			
Corrected Total	2870.028	274			

Note. $p \leq 0.01$.

Table 20

Descriptive Statistics and Two-Way ANOVA for Gender and Student Status on Low Self-Worth

Gender	Group	*n*	*M*	*SD*
Females	Incoming	133	8.29	3.18
	Exiting	94	7.96	3.82
	Overall	227	8.15	3.45
Males	Incoming	22	8.45	2.94
	Exiting	26	7.88	3.36
	Overall	48	8.15	3.16
Total	Incoming	155	8.31	3.14
	Exiting	120	7.95	3.71
	Overall	275	8.15	3.40

Source	*SS*	*df*	*MS*	*F*	*p*
Gender	0.075	1	0.075	0.006	0.936
Group	7.890	1	7.890	0.678	0.411
Gender*Group	0.576	1	0.576	0.049	0.824
Error	3154.412	271	11.640		
Total	21441.946	275			
Corrected Total	3164.193	274			

Note. $p \leq 0.01$.

Gender and student status on Hiding Self. As detailed in Table 21, there was not a significant interaction effect between student status and gender on the codependency variable Hiding Self ($p = 0.277$). Although a main effect did not exist in relation to student status ($p = 0.175$), a main effect was present with regard to gender on the core area of Hiding Self ($p = 0.007$). Students' tendency to hide the true self was not dependent on the interaction of their status within the program and their gender.

However, there was a significant difference between males and females with regard to reporting the need to hide self. Males ($M = 11.94$, $SD = 3.11$) reported a greater tendency to hide the true self than did females ($M = 10.49$, $SD = 3.59$).

Table 21

Descriptive Statistics and Two-Way ANOVA for Gender and Student Status on Hiding Self

Gender	Group	*n*	*M*	*SD*
Females	Incoming	133	10.56	3.67
	Exiting	94	10.40	3.49
	Overall	227	10.49	3.59
Males	Incoming	22	12.68	3.09
	Exiting	26	11.31	3.04
	Overall	48	11.94	3.11
Total	Incoming	155	10.86	3.66
	Exiting	120	10.60	3.41
	Overall	275	10.75	3.55

Source	*SS*	*df*	*MS*	*F*	*p*
Gender	89.877	1	89.877	7.284	0.007*
Group	22.822	1	22.822	1.850	0.175
Gender*Group	14.629	1	14.629	1.186	0.277
Error	3343.777	271	12.339		
Total	35203.000	275			
Corrected Total	3450.182	274			

*$p \leq 0.01$.

Gender and student status on Medical Problems. A significant interaction effect was not found to exist between student status and gender on the CODAT core area Medical Problems ($p = 0.682$) (Table 22). The effect of student status on Medical Problems was not dependent on gender. Additionally, there were no main effects found to exist for either gender ($p = 0.596$) or student status ($p = 0.203$) on the CODAT core area Medical Problems. Students from the incoming group did not score significantly

Table 22

Descriptive Statistics and Two-Way ANOVA for Gender and Student Status on Medical Problems

Gender	Group	*n*	*M*	*SD*
Females	Incoming	133	6.93	2.80
	Exiting	94	7.32	3.09
	Overall	227	7.09	2.92
Males	Incoming	22	6.50	1.92
	Exiting	26	7.27	2.89
	Overall	48	6.92	2.50
Total	Incoming	155	6.87	2.69
	Exiting	120	7.31	3.04
	Overall	275	7.06	2.85

Source	*SS*	*df*	*MS*	*F*	*p*
Gender	2.301	1	2.301	0.282	0.596
Group	13.283	1	13.283	1.630	0.203
Gender*Group	1.371	1	1.371	0.168	0.682
Error	2208.872	271	8.151		
Total	15941.405	275			
Corrected Total	2225.757	274			

Note. $p \leq 0.01$.

different from those in the exiting group with regard to Medical Problems. Also, there was not a significant difference in group scores for males when compared to females.

Gender and student status on Family of Origin Issues. A significant interaction effect or main effect was found not to exist between student status and gender on the CODAT core area Family of Origin Issues ($p = 0.191$) (Table 23). Also, it was found that

Table 23

Descriptive Statistics and Two-Way ANOVA for Gender and Student Status on Family of Origin Issues

Gender	Group	*n*	*M*	*SD*
Females	Incoming	133	14.09	5.71
	Exiting	94	12.95	5.31
	Overall	227	13.62	5.56
Males	Incoming	22	11.73	4.25
	Exiting	26	12.85	5.00
	Overall	48	12.33	4.66
Total	Incoming	155	13.76	5.57
	Exiting	120	12.92	5.22
	Overall	275	13.39	5.43

Source	*SS*	*df*	*MS*	*F*	*p*
Gender	59.492	1	59.492	2.034	0.155
Group	0.007	1	0.007	0.000	0.988
Gender*Group	50.224	1	50.224	1.717	0.191
Error	7924.798	271	29.243		
Total	57405.603	275			
Corrected Total	8077.267	274			

Note. $p \leq 0.01$.

a significant main effect did not exist for either student status ($p = 0.988$) or gender ($p = 0.155$) on the variable Family of Origin Issues. Respondents' perceived level of satisfaction with the communication and coping style of their family of origin was not dependent on their status within the program or their gender.

Whereas a significant difference was found to exist between males and females on the core area Hiding Self ($p = 0.010$), significant interaction effects were not found to exist between student status and gender on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues. Therefore, the null hypothesis was retained.

Religious Preference

Religious preference on the composite codependency score

An open-ended question on the demographic portion of the CODAT asked individuals to identify their religious preferences. A total of 35 different religious affiliations were presented by the respondents. A generally accepted approach to classifying religion maintains that there are four prominent groups: Protestant, Catholic, Orthodox, and Other. For the purpose of this investigation, these groups were used with one exception. Due to the small number of students who identified with the Orthodox group (2), these individuals were combined with individuals in the Other group. These religious preferences were then grouped according to Protestant, Catholic, and Other.

A one-way ANOVA was used to determine if a significant difference in a composite codependency score on the CODAT was present among respondents in the religious preference groups Protestant ($M = 49.14$, $SD = 12.79$), Catholic ($M = 48.17$,

SD = 11.88), and Other (*M* = 49.18, *SD* = 10.65) (Table 24). There was not a significant difference among these religious groups with regard to the composite score ($p = 0.918$).

Table 24

Descriptive Statistics and One-Way ANOVA for Religious Preference on the Composite CODAT Score

Religious Preference	*n*	*M*	*SD*
Protestant	173	49.14	12.79
Catholic	30	48.17	11.88
Other	64	49.18	10.65

Source	*SS*	*df*	*MS*	*F*	*p*
Between Groups	25.560	2	12.780	0.086	0.918
Within Groups	39373.616	264	149.142		
Total	39399.175	266			

Religious preference on the CODAT core areas

The descriptive statistics for religious preference on the core areas are located in Table 25. A one-way ANOVA was conducted for each of the five core areas to determine if a significant difference among the religious preferences was present (Table 26). A Bonferroni adjustment was made to control for Type I error that may be present when group comparisons were made on multiple variables. A significance level of 0.01 was used rather than a level of 0.05.

There were no significant differences among groups based on religious preferences on the CODAT core areas Other Focus/Self-Neglect ($p = 0.762$),

Table 25

Descriptive Statistics for Religious Preference on the Core Areas

Variable	Religious Preference	*n*	*M*	*SD*
Other Focus/Self-Neglect	Protestant	173	9.73	3.29
	Catholic	30	9.45	2.94
	Other	64	9.41	3.38
	Total	267	9.62	3.27
Low Self-Worth	Protestant	173	8.32	3.53
	Catholic	30	7.73	1.96
	Other	64	8.05	3.73
	Total	267	8.19	3.44
Hiding Self	Protestant	173	10.78	3.69
	Catholic	30	10.73	3.41
	Other	64	10.63	3.42
	Total	267	10.73	3.58
Medical Problems	Protestant	173	7.09	3.00
	Catholic	30	8.02	3.10
	Other	64	6.66	2.30
	Total	267	7.09	2.88
Family of Origin Issues	Protestant	173	13.23	5.49
	Catholic	30	12.23	4.72
	Other	64	14.44	5.67
	Total	267	13.41	5.47

Table 26

One-Way ANOVAs for Religious Preference on the Core Areas

Core Area	Source	*SS*	*df*	*MS*	*F*	*p*
Other Focus/Self-Neglect	Between Groups	5.854	2	2.927	0.272	0.762
	Within Groups	2835.611	264	10.741		
	Total	2841.464	266			
Low Self-Worth	Between Groups	10.271	2	5.136	0.433	0.649
	Within Groups	3130.946	264	11.860		
	Total	3141.217	266			
Hiding Self	Between Groups	1.045	2	0.523	0.040	0.960
	Within Groups	3411.075	264	12.921		
	Total	3412.120	266			
Medical Problems	Between Groups	37.999	2	18.999	2.318	0.100
	Within Groups	2163.645	264	8.196		
	Total	2201.644	266			
Family of Origin Issues	Between Groups	115.000	2	57.500	1.934	0.147
	Within Groups	7849.180	264	29.732		
	Total	7964.180	266			

Note. $p \leq 0.01$.

Low Self-Worth ($p = 0.649$), Hiding Self ($p = 0.960$), Medical Problems ($p = 0.100$), and Family of Origin Issues ($p = 0.147$).

Religious preference and student status on the composite CODAT Score

A two-way ANOVA was used to determine that a significant interaction effect did not exist between student status and religious preference on the composite CODAT score ($p = 0.056$). There were also no main effects present between incoming and exiting

students ($p = 0.883$) or religious preference groups ($p = 0.917$) with regard to level of codependency as assessed by the CODAT (Table 27).

Table 27

Descriptive Statistics and Two-Way ANOVA for Religious Preference and Student Status on the Composite CODAT Score

Student Status	Religious Preference	*n*	*M*	*SD*
Incoming	Protestant	99	51.17	13.26
	Catholic	17	48.04	11.53
	Other	34	47.49	7.75
Exiting	Protestant	74	46.43	11.67
	Catholic	13	48.35	12.79
	Other	30	51.08	13.08
Overall	Protestant	173	49.14	12.79
	Catholic	30	48.17	11.88
	Other	64	49.18	10.65

Source	*SS*	*df*	*MS*	*F*	*p*
Group	3.183	1	3.183	0.022	0.883
Religious Preference	25.425	1	12.712	0.087	0.917
Group*Religious Pref.	854.855	1	427.428	2.919	0.056
Error	38214.222	261	146.415		
Total	681524.800	267			
Corrected Total	39399.175	266			

Religious preference and student status on the CODAT core areas

Null Hypothesis 5: There are no significant interaction effects between student status and religious preference on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Because the groups were being compared on multiple variables, to control for Type I error a Bonferroni adjustment was made. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

Religious preference and student status on Other Focus/Self-Neglect. As outlined in Table 28, a significant interaction effect was not found to exist between student status and religious preference on the core area Other Focus/Self-Neglect ($p = 0.160$). Additionally, there was not a main effect present on either student status ($p = 0.479$) or religious preference ($p = 0.893$) with regard to Other Focus/Self-Neglect. Students' tendencies to feel responsible for helping with the needs of others at the cost of neglecting their own needs was not dependent on their status in the counseling program or their religious preference.

Religious preference and student status on Low Self-Worth. As illustrated in Table 29, a significant interaction effect was not found to exist between student status and religious preference on the CODAT core area Low Self-Worth ($p = 0.041$). Additionally, a main effect was not present for either student status ($p = 0.875$) or religious preference ($p = 0.762$) on Low Self-Worth. Students' level of self-worth was not dependent on either their status in the MAC program or their religious preference.

Table 28

Descriptive Statistics and Two-Way ANOVA for Religious Preference and Student Status on Other Focus/Self-Neglect

Student Status	Religious Preference	*n*	*M*	*SD*
Incoming	Protestant	99	10.36	3.49
	Catholic	17	9.29	2.59
	Other	34	9.40	3.50
	Total	150	10.02	3.41
Exiting	Protestant	74	8.89	2.83
	Catholic	13	9.66	3.45
	Other	30	9.41	3.29
	Total	117	9.11	3.01
Overall	Protestant	173	9.73	3.29
	Catholic	30	9.45	2.94
	Other	64	9.41	3.38
	Total	267	9.62	3.27

Source	*SS*	*df*	*MS*	*F*	*p*
Group	5.277	1	5.277	0.502	0.479
Religious Preference	2.381	1	1.190	0.113	0.893
Group*Religious Pref.	38.799	1	19.400	1.845	0.160
Error	2743.645	261	10.512		
Total	27560.744	267			
Corrected Total	2841.464	266			

Note. $p \leq 0.01$.

Table 29

Descriptive Statistics and Two-Way ANOVA for Religious Preference and Student Status on Low Self-Worth

Student Status	Religious Preference	*n*	*M*	*SD*
Incoming	Protestant	99	8.81	3.50
	Catholic	17	7.71	2.28
	Other	34	7.41	2.10
	Total	150	8.37	3.17
Exiting	Protestant	74	7.65	3.49
	Catholic	13	7.77	1.54
	Other	30	8.77	4.89
	Total	117	7.95	3.76
Overall	Protestant	173	8.32	3.53
	Catholic	30	7.73	1.96
	Other	64	8.05	3.73
	Total	267	8.19	3.44

Source	*SS*	*df*	*MS*	*F*	*p*
Group	0.289	1	0.289	0.025	0.875
Religious Preference	6.339	1	3.169	0.272	0.762
Group*Religious Pref.	75.411	1	37.705	3.233	0.041
Error	3044.216	261	11.664		
Total	21030.719	267			
Corrected Total	3141.217	266			

Note. $p \leq 0.01$.

Religious preference and student status on Hiding Self. As detailed in Table 30, a significant interaction effect was not found to exist between student status and religious preference on the core area Hiding Self ($p = 0.842$). Additionally, a significant main effect was not present for either student status ($p = 0.689$) or religious preference ($p = 0.979$) on Hiding Self.

Table 30

Descriptive Statistics and Two-Way ANOVA for Religious Preference and Student Status on Hiding Self

Student Status	Religious Preference	*n*	*M*	*SD*
Incoming	Protestant	99	10.98	3.91
	Catholic	17	10.88	3.90
	Other	34	10.56	2.96
	Total	150	10.87	3.70
Exiting	Protestant	74	10.50	3.36
	Catholic	13	10.54	2.79
	Other	30	10.70	3.93
	Total	117	10.56	3.44
Overall	Protestant	173	10.78	3.69
	Catholic	30	10.73	3.41
	Other	64	10.63	3.42
	Total	267	10.73	3.58

Source	*SS*	*df*	*MS*	*F*	*p*
Group	2.097	1	2.097	0.161	0.689
Religious Preference	0.565	1	0.283	0.022	0.979
Group*Religious Pref.	4.473	1	2.236	0.172	0.842
Error	3400.137	261	13.027		
Total	34176.000	267			
Corrected Total	3412.120	266			

Note. $p \leq 0.01$.

Religious preference and student status on Medical Problems. As indicated in Table 31, a significant interaction effect was not found to exist between student status and religious preference on the core area Medical Problems ($p = 0.282$). Also, a main effect was not present on either student status ($p = 0.055$) or religious preference ($p = 0.079$) on Medical Problems. Respondents' status in the MAC program and their religious preference did not significantly affect their reported level of preoccupation with physical ailments.

Religious preference and student status on Family of Origin Issues. As depicted in Table 32, a significant interaction effect was not found to exist between student status and religious preference on the core area Family of Origin Issues ($p = 0.214$). In addition, a significant main effect was not present on either student status ($p = 0.452$) or religious preference ($p = 0.106$) with regard to Family of Origin Issues. Students' level of satisfaction with the openness, communication style, and coping strategies of their families was not dependent on the interaction or isolated effects of student status and religious preference.

A significant interaction effect was not found to exist between student status and religious preference on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, or Family of Origin Issues. Therefore, the null hypothesis was retained.

Table 31

Descriptive Statistics and Two-Way ANOVA for Religious Preference and Student Status on Medical Problems

Student Status	Religious Preference	*n*	*M*	*SD*
Incoming	Protestant	99	7.07	3.06
	Catholic	17	7.33	2.27
	Other	34	6.21	1.51
	Total	150	6.90	2.72
Exiting	Protestant	74	7.12	2.94
	Catholic	13	8.92	3.84
	Other	30	7.17	2.89
	Total	117	7.33	3.06
Overall	Protestant	173	7.09	3.00
	Catholic	30	8.02	3.10
	Other	64	6.66	2.30
	Total	267	7.09	2.88

Source	*SS*	*df*	*MS*	*F*	*p*
Group	30.398	1	30.398	3.725	0.055
Religious Preference	41.938	1	20.969	2.569	0.079
Group*Religious Pref.	20.753	1	10.377	1.271	0.282
Error	2130.149	261	8.161		
Total	15624.405	267			
Corrected Total	2201.644	266			

Note. $p \leq 0.01$.

Table 32

Descriptive Statistics and Two-Way ANOVA for Religious Preference and Student Status on Family of Origin Issues

Student Status	Religious Preference	*n*	*M*	*SD*
Incoming	Protestant	99	13.95	5.69
	Catholic	17	12.82	4.99
	Other	34	13.92	5.73
	Total	150	13.81	5.60
Exiting	Protestant	74	12.27	5.08
	Catholic	13	11.46	4041
	Other	30	15.03	5.63
	Total	117	12.89	5.28
Overall	Protestant	173	13.23	5.49
	Catholic	30	12.23	4.71
	Other	64	14.44	5.67
	Total	267	13.41	5.47

Source	*SS*	*df*	*MS*	*F*	*p*
Group	16.730	1	16.730	0.567	0.452
Religious Preference	133.341	1	66.670	2.261	0.106
Group*Religious Pref.	91.544	1	45.772	1.552	0.214
Error	7696.448	261	29.488		
Total	55968.603	267			
Corrected Total	7964.180	266			

Note. $p \leq 0.01$.

Summary

Collectively, respondents' composite CODAT score placed them at the minimal level of codependency. The majority of students scored in the Minimal range, with some students scoring in the Mild to Moderate range and the Moderate range. There were no students who scored in the Severe range. Of the five core areas, students scored in the Mild to Moderate range in the areas of Family of Origin Issues and Hiding Self. Students scored in the minimal range on the areas of Other Focus/Self-Neglect, Low Self-Worth, and Medical Problems. Respondents scored highest on items from the core area Family of Origin Issues, indicating that the communication style in their family of origin was not as open as they would have liked. Participants scored lowest on an item in the core area Low Self-Worth, suggesting that they had a fairly positive self-image.

There was no significant difference on composite CODAT score between incoming and exiting students. In addition, there were no significant differences between incoming and exiting students on the core areas.

There were no significant differences in scores for either the CODAT composite or the core areas among the different age groups. There was a significant interaction effect between student status and age with regard to participants' composite score on the CODAT. Within the 22 to 27 age group, incoming students ($M = 51.40$, $SD = 12.96$) scored significantly higher on the composite CODAT score when compared to that of the exiting students ($M = 40.65$, $SD = 9.39$). Also, a significant interaction effect was found to exist between age and student status on the CODAT core area Low Self-Worth ($p = 0.009$). For the exiting students, individuals in the 22 to 27 age range ($M = 6.53$, $SD = 2.18$) scored significantly lower than the individuals in the 28 to 34 age range

($M = 9.29$, $SD = 5.04$). Individuals in the 22 to 27 age range reported more positive self-worth when compared to individuals in the 28 to 34 age range. Within the 22 to 27 age group, incoming students ($M = 9.37$, $SD = 3.85$) scored significantly higher on Low Self-Worth when compared to the exiting students ($M = 6.53$, $SD = 2.18$). There were no other significant group differences found between the incoming and exiting students. A significant interaction effect was not found to exist between student status and age on any of the remaining core areas of Other Focus/Self-Neglect, Hiding Self, Medical Problems, or Family of Origin Issues.

With regard to gender, there was no significant difference between the composite CODAT score of the females when compared to that of the males. There was a significant difference between males ($M = 11.94$, $SD = 3.11$) and females ($M = 10.49$, $SD = 3.59$) on the core area Hiding Self ($p = 0.010$). Males reported a greater tendency to hide their true selves when compared to females. There were no significant differences on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Medical Problems, and Family of Origin Issues with regard to gender. There were no significant interaction effects present between student status and gender on the composite score or on the core areas Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, or Family of Origin Issues.

With regard to religious preference, there was no significant difference among the religious preferences of Protestant, Catholic, and Other on the CODAT composite score. There were no significant differences among these religious groups on the CODAT core areas. Additionally, there were no significant interaction effects present between religious preference and student status on either the composite score or on the core areas.

CHAPTER V

SUMMARY, DISCUSSION, AND RECOMMENDATIONS

This chapter summarizes the problem, the purpose of the study, the literature review, and the methodology. The findings of this investigation are also reviewed and discussed. Implications and recommendations for counselor education programs are identified, as well as recommendations for future research.

Statement of the Problem

Counseling, by its very nature, is a relational intervention. A counselor with a codependent style of relating brings unhealthy relational patterns to the therapeutic relationship. A codependent counselor attempts to control the feelings, actions, and thoughts of clients through manipulation and compulsive advice-giving. Furthermore, a counselor with codependent characteristics has an exaggerated need to be needed, which fosters client dependency and helplessness (Corey et al., 2003). For example, a counselor with codependent tendencies demonstrates a need to "rescue" or "fix" others, even to the extent of self-neglect (Fausel, 1988). Codependency in a therapeutic relationship may manifest itself when a counselor compromises the therapeutic process to gain client approval, maintains the role of being an infallible expert, or delays client termination in pursuit of a personal agenda. When a counselor's codependent relational patterns enter into the therapeutic relationship, clients are robbed of a corrective interpersonal

experience, lose the opportunity to learn healthier patterns of relating, and have a reinforced perception of being helpless.

Purpose of the Study

A clear responsibility has been placed on counselor training programs to safeguard both client welfare and the counseling profession. Counseling programs are increasingly being charged to go beyond monitoring students' academic achievement and skill performance, to assessing students' personal characteristics.

A student's personal characteristics include relational patterns. Counselor training programs need to be mindful of the possibility that codependent patterns of relating may be present in some students and that these patterns may pose a threat to establishing and maintaining a functional therapeutic relationship. Since a career in counseling attracts nurturing individuals, counselor education programs must discern whether this nurturing stems from healthy tendencies or codependent motives.

The purpose of this study was to explore the prevalence of codependent personality traits among master's-level counseling students. The results of this exploration may improve curricular development for counselor education programs.

Three research questions were addressed:

Research Question 1: What is the level of codependency in master's-level counseling students?

Research Question 2: Is there a significant difference in level of codependency between incoming and exiting master's-level counseling students?

Research Question 3: Is codependency in master's-level counseling students related to age, gender, or religious preference?

Overview of the Literature

Confusion and debate surround the codependency construct in the professional literature. Proponents of the codependency construct advocated that codependency is a valuable construct to facilitate communication among professionals, help individuals understand and normalize their experiences, and provide an explanation for dysfunctional patterns of relating. Some considered codependency to be a personality style that warrants inclusion in the *DSM-IV-TR* (APA, 2000). Others insisted that it is a social construct resulting from societal inequalities and socialized gender role. Opponents of the construct contended that it lacks diagnostic discriminative validity. They considered codependency to be an overgeneralized buzzword used to stereotype individuals. They warned that codependency has become big business, placing people at risk for exploitation.

Although inconclusive, the literature appears to support codependency as a personality construct in which individuals share predictable behaviors and relational patterns. However, the literature seems to yield insufficient evidence to substantiate the recognition of codependency as a *DSM –IV-TR* (APA, 2000) personality disorder. It appears to lack discriminative diagnostic validity, and any attempts made to operationalize this construct have lacked empirical support.

The professional literature contained a substantial amount of research using a codependency construct to describe the relational patterns of individuals in a dysfunctional family system or experiencing chemical dependency. Brief consideration was given to the prevalence of codependent traits among nursing students. However,

inadequate consideration was given to how people with codependent tendencies may seek out a career in counseling to fulfill personal needs.

For the purposes of this investigation, the theoretical framework of the codependency construct was considered along five main dimensions that dominate the professional literature. First, codependent individuals typically focus on others to the point of self-neglect (Fischer & Crawford, 1992; Fuller & Warner, 2000; Granello & Beamish, 1998; O'Brien & Gaborit, 1992; Wright & Wright, 1999). This focus may manifest itself as attempting to control others, taking responsibility for meeting the needs of others, and having enmeshed relationships with others. Codependents lose touch with their own thoughts and feelings.

Second, codependent individuals have a low sense of self-worth (O'Brien & Gaborit, 1992; Springer et al., 1998). This low self-esteem often results from an individual's strong feelings of shame. These individuals attempt to gain their self-esteem through the approval of others or vicariously through the success of significant others. Attempts to increase self-worth are also sought through their willingness to "suffer" for the sake of others.

Third, codependent individuals develop a false self that serves to hide the true self (Carson & Baker, 1994; Morgan, 1991). Since these individuals focus almost exclusively on the needs of others, their personal identity is unable to truly form. Individuals deny any feelings and thoughts that pose a risk of rejection by significant others. A false self emerges that is compatible with the self that others will approve and accept. After prolonged hiding of the true self, the individual is rarely able to distinguish his/her real self from that of others.

Fourth, codependent individuals are preoccupied with real or imagined medical problems (Fagan-Pryor & Haber, 1992; Gotham & Sher, 1996). As a result of neglecting personal needs, mismanaging anxiety surrounding relationships, experiencing associated feelings of shame and low self-worth, and hiding the true self, these individuals tend to manifest their relational dysfunction as somatic complaints.

Finally, codependent individuals have dysfunctional relational dynamics in their family of origin (Burris, 1999; Clark & Stoffel, 1992; Cowan et al., 1995; Cullen & Carr, 1999; Fischer & Crawford, 1992; Prest & Protinsky, 1993). This dysfunction may include childhood abuse, enmeshment, authoritarian parenting styles, and non-nurturance. Children growing up in dysfunctional families learn to survive in their home environments by being overly sensitive to the needs of others. Frequently in these dysfunctional families the parent-child roles have become reversed so that the children are forced to demonstrate parentified behaviors as they take care of needy parents. These children learn that fixing the problems of other people is a means of preserving one's self-worth.

Methodology

The population for this investigation was comprised of 275 Spring Arbor University students enrolled in the Master of Arts in Counseling (MAC) program. Two cross sections of the student population were examined, and these cross sections were referred to as incoming students and exiting students.

Students were administered the Codependency Assessment Tool (CODAT), a 25-item multivariate tool designed by Hughes-Hammer et al. (1998b) to measure codependency in adults. This instrument measures codependency along five core areas:

Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues. Specifically, Other Focus/Self-Neglect is defined as the compulsion to help or control others through advice-giving or manipulation. Low Self-Worth assesses individuals' propensity for self-criticism, shame, self-blame, and humiliation. Hiding Self reflects the codependent individuals' tendency to falsify feelings by displaying positive emotions and denying negative ones. Medical Problems measures the individuals' tendency to be preoccupied with real or imagined somatic complaints. Finally, Family of Origin Issues is used to characterize individuals' current unhappiness as a result of growing up in families that were dysfunctional.

Incoming students were given the CODAT during the MAC orientation night. Exiting students were given the assessment during one of their scheduled internship seminar nights, the last course of the MAC program. To ensure uniform delivery, I read standardized information about the study and assessment tool for both the incoming and the exiting groups. Students had ample time to finish the assessment. Steps were taken to ensure student anonymity.

Statistical analysis was conducted at $\alpha = 0.05$. The exception to this was the analysis of data surrounding the five core areas. In these instances, groups were being compared on multiple variables, so the potential for inflation of Type I error was present. To control for this error, a Bonferroni adjustment was made. As a result, analyses of these core areas were conducted using a significance level of 0.01 rather than 0.05.

Discussion of Findings

There was a total of 275 actual participants, ranging from 22 to 63 years of age, whose mean age was 36.54 (SD =10.03). The majority of the sample was comprised of

female students (82.5%) compared to the number of male students (17.5%). The ethnicity of the group was predominately Caucasian (77.8%) followed by African American (18.2%), Hispanic (1.5%), and Other (1.8%). With regard to religious preference, almost all of the participants identified themselves as being affiliated with a Christian religion. A minority of individuals (5.1%) considered their religious affiliation to be non-Christian.

The majority of students denied any previous mental health hospitalizations (93.8%) or problems with substance abuse (89.5%). Seventeen participants (6.1%) reported previous hospitalizations due to mental health concerns. These hospitalizations ranged from one to eight times and were attributed to problems with major depression, suicide attempts, anxiety, eating disorders, or bipolar illness with psychotic features. Twenty-eight individuals (10.2%) reported a past or present struggle with substance abuse. Forty-nine (17.8%) of the participants indicated that their spouse/significant other has experienced substance abuse problems, and 68 (24.7%) students reported having a parent who has experienced problems with substance abuse.

Three research questions guided this investigation.

Research Question 1: What is the level of codependency among master's-level counseling students?

Respondents' CODAT mean score (48.99) placed them at the minimal level of codependency. The majority of students scored in the Minimal range (57.5%), with some students scoring in the Mild to Moderate range (38.9 %) and the Moderate range (3.6%). There were no students who scored in the Severe range. It is interesting to note that although 158 students scored in the Minimal range, their mean score was at the high end of this level and only 1 point from entering into the Mild to Moderate range.

Furthermore, 43% of the respondents scored at a level higher than the Minimal range. Although this does not suggest that these counseling students are codependent, it does present cause for concern that some of these students have codependent tendencies that may impact their personal and professional development.

Of the five core areas, students scored in the Mild to Moderate range in the areas of Family of Origin Issues and Hiding Self. Mean scores in the areas of Other Focus/Self-Neglect, Low Self-Worth, and Medical Problems were in the Minimal range.

Collectively, respondents scored highest on items from the core area Family of Origin Issues, which dealt with openness of communication, indicating that the communication style in their family of origin was not as open as they would have liked. A second area of concern surrounded Hiding Self. Students indicated they tended to hide their true selves, falsifying feelings by displaying positive emotions and denying negative ones.

Although these two areas of concern do not mandate that students will be ineffective in their communication with clients and in their authenticity in therapeutic relationships, these concerns do highlight the importance of being aware of any unhealthy relating patterns students may have learned. It is important for therapists to be able to model to clients healthy patterns of relating. Lambert (1992) indicated that 30% of clients' growth can be attributed to factors of the therapeutic relationship. He identified these factors to be empathy, unconditional positive regard, and warmth. Carl Rogers (1957) also emphasized that unconditional positive regard, empathy, and authenticity on the part of the therapist provide the necessary and sufficient conditions for clients'

positive change. Exaggerated tendencies to hide one's true self may interfere with the development of these therapeutic conditions.

Research Question 2: Is there a significant difference in the level of codependency between incoming and exiting master's-level counseling students?

Null Hypothesis 1: There is no significant difference between incoming and exiting students on the CODAT composite score.

An independent *t* test was used to determine that there was no significant difference on the composite score between incoming and exiting counseling students. As a result, the null hypothesis was retained.

Null Hypothesis 2: There are no significant differences between incoming and exiting students on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Additional *t* tests were conducted to find that there were no significant differences between incoming and exiting students on the core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, or Family of Origin Issues. Therefore, the null hypothesis was retained.

A possible explanation for this lack of difference between incoming and exiting students is that the curriculum in Spring Arbor University's MAC program does not influence codependency factors as measured by the CODAT. The data would suggest that the MAC program does not appear to foster the development of codependent tendencies in students. Unfortunately, neither does the counseling program appear to decrease the level of codependent tendencies in students.

Another possible explanation for the lack of differences in the CODAT scores between incoming and exiting students has to do with self-awareness. Any benefit of a decrease in codependent tendencies that the respondents received from the curriculum may have been offset by an increase in their level of self-awareness and an increase in their willingness to self-disclose. These increases may have caused the students to be more sensitive to the instrument.

Research Question 3: Is codependency in master's-level counseling students related to age, gender, or religious preference?

A one-way ANOVA yielded that there were no significant differences among the age groups on the CODAT composite score. Additionally, there were no significant differences among the age groups with regard to the five core areas.

In examining the effect of gender, an independent *t* test was conducted and found that there was no significant difference between the composite CODAT score of the females when compared to that of the males. Although these findings were inconsistent with popular belief that codependency is predominately associated with females (Clark & Stoffel, 1992), data did align with the work of Martsolf et al. (2000), who indicated that there were no significant differences between males and females with regard to codependency.

Fuller and Warner (2000) offered a possible explanation for this discrepancy. They suggested that the presence of gender differences in codependency was dependent on the assessment instrument used. For example, men were more willing to report that they had certain characteristics that are included in the Potter-Efron Codependency Scale such as rage, rigidity, and denial than they were to report characteristics that were

included in the Spann-Fischer scale such as worry, guilt, or painful relationships. Based on the results of this current investigation it appears that the CODAT contained items that were equally comfortable for both males and females to report.

Independent *t* tests indicated that there were no significant differences on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Medical Problems, and Family of Origin Issues with regard to gender. However, there was a significant difference between males ($M = 11.94$, $SD = 3.11$) and females ($M = 10.49$, $SD = 3.59$) on the core area Hiding Self ($p = 0.010$). Males, scoring in the Mild to Moderate range, reported a greater tendency to hide their true selves when compared to females. O'Neil, Helms, and Gable (1986) attributed males' tendency to hide their true selves to the socialized male gender role. Men fear that engaging in emotional expression and self-disclosure will make them appear weak. As a result, many men experience restricted emotionality. Because male gender role issues, such as restricted emotionality, can interfere with interpersonal relationships, addressing these issues is an important aspect of improving the training of male therapists (Webster, Vogel, & Archer, 2004; Wisch & Mahalik, 1999).

With regard to religious preference, ANOVA results indicated that there was no significant difference among the religious preferences of Protestant, Catholic, and Other with regard to the CODAT composite score. There were also no significant differences among these religious groups on the CODAT core areas.

Hypothesis 3: There are no significant interaction effects between student status and age on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Two-way ANOVA results yielded that a significant interaction effect was found to exist between age and student status on the CODAT core area Low Self-Worth ($p = 0.009$). For the exiting students, individuals in the 22 to 27 age range ($M = 6.53$, $SD = 2.18$) scored significantly lower than the individuals in the 28 to 34 age range ($M = 9.29$, $SD = 5.04$). Exiting individuals in the 22 to 27 age range reported more positive self-worth when compared to exiting individuals in the 28 to 34 age range.

A possible explanation for this difference is that the students in the 22 to 27 age range possessed more self-confidence because they were about to earn a graduate degree at a relatively young age. Students in the 28 to 34 age range may have had a greater opportunity to experience more life responsibilities that come with marriage, children, and the world of work. These experiences may have challenged some of their perceptions of their own abilities or worth. Additionally, students in the younger age range may have had more flexibility to benefit more from the content of the MAC program because they were not as set in their patterns of beliefs and behaviors.

There were no significant age group differences found for the incoming students. Within the 22 to 27 age group, incoming students ($M = 9.37$, $SD = 3.85$) scored significantly higher on the Low Self-Worth score when compared to the exiting students ($M = 6.53$, $SD = 2.18$). A possible explanation for this difference is that these young students were coming to a new program, and they may have been uncertain as to whether or not they would be successful. For example, these students may have been entering the program after having been denied at other institutions, having low Graduate Record Exam (GRE) scores, or having been admitted to the program on a conditional basis. The

fact that exiting students reported a more positive self-worth suggests that the 3-year MAC program may have served as a positive growth experience.

Significant interaction effects did not exist between student status and age on any of the remaining core areas of Other Focus/Self-Neglect, Hiding Self, Medical Problems, or Family of Origin Issues. Since a significant interaction effect was present between age and student status on Low Self-Worth, the null hypothesis was rejected.

Hypothesis 4: There are no significant interaction effects between student status and gender on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Two-way ANOVAs were used to determine that significant interaction effects were not found to exist between student status and gender on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues. Therefore, the null hypothesis was retained.

As mentioned earlier, males did report a need to hide the true self significantly more than females. The fact that there was no significant interaction effect between gender and student status suggests that the MAC curriculum did not impact males' tendencies to hide their true selves.

Hypothesis 5: There are no significant interaction effects between student status and religious preference on the CODAT core areas of Other Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, and Family of Origin Issues.

Two-way ANOVAs indicated that significant interaction effects did not exist between student status and religious preference on the CODAT core areas of Other

Focus/Self-Neglect, Low Self-Worth, Hiding Self, Medical Problems, or Family of Origin Issues. Therefore, the null hypothesis was retained.

Summary

The self-report of these counseling students did not indicate that there was a high level of codependency present or that there was a significant difference in the level of codependency between incoming and exiting students. Students' composite scores did suggest that codependent tendencies were present in a majority of the students. Additionally, students expressed dissatisfaction with the openness of communication in their family of origin and reported a tendency to hide their true selves. On the CODAT, individuals who scored high on the core area Hiding Self endorsed items that reflected a tendency to experience restricted emotionality and lack of authenticity. Since both communication style and authenticity are important factors in a therapeutic relationship, this may be cause for concern.

Implications for Counselor Education Programs

The purpose of this study was to investigate the prevalence of codependent personality traits among master's-level counseling students. Although the composite codependency score did not indicate that a problem with codependency existed, the results did suggest that tendencies toward codependency were present. These results raise some concern and indicate that students would benefit from personal growth in this area.

Counselor training programs are encouraged to consider that codependent patterns of relating may be present in some students and that these patterns may pose a threat to establishing and maintaining a functional therapeutic relationship. It may be beneficial

for training programs to address these dynamics in the curriculum, helping students to increase awareness of their own unhealthy relational patterns, to identify their unmet needs, and to explore appropriate means of personal need fulfillment that extend beyond the therapeutic relationship.

Recommendations for Counselor Education Programs

As a result of this investigation, the following considerations are recommended for counselor education programs:

1. Counselor training programs should develop strategies for identifying students who do experience a significant level of codependent tendencies and provide these students with appropriate interventions. Depending on the severity of the codependency, interventions may range from simply dialoguing with the student to requiring the student to seek outside professional assistance as a condition of remaining in the counseling program.

2. Counselor training programs should examine how students' perceptions of communication dynamics in their family of origin may impact their relationships with clients.

3. Counselor training programs should assist students to assess their tendencies to hide their true selves. Faculty can seek opportunities to dialogue with students about how a lack of authenticity may affect their ability to enter into a therapeutic relationship. Faculty can assist students to discern when it is safe and appropriate to share one's true self with others. Also, faculty can explore with students how restricted emotionality and other aspects of socialized gender roles may influence the therapeutic relationship.

Recommendations for Further Study

Based on the findings of this study, recommendations for further study include the following:

1. Research should be conducted using a broader student population to extend beyond the students of a single, faith-based university.

2. Exploration from a longitudinal perspective needs to be conducted, using the same students as they enter and exit the program.

3. Investigation should compare the level of codependency in counseling students with that of students in other academic programs, for example, business, engineering, music. Assuming that most people will share some codependent characteristics, this comparison will help the researcher to determine if the level of codependency in counseling students is truly elevated in comparison to that of the general population.

4. Research should be pursued that implements other assessment instruments to measure students' level of codependency, for example, Spann-Fischer Codependent Scale, Potter-Efron Codependency Scale.

Conclusion

Although the data showed only a minimal level of codependency, it is hoped that by documenting the existence of these characteristics in counseling students, we can encourage other counselor education programs to become aware of codependency in their trainees. This heightened awareness will allow counselor education programs to infuse in the curricula strategies that will assist students to recognize their own codependent tendencies and appropriately manage them.

APPENDIX A

INSTRUMENTATION

CODAT

Directions: This instrument is called the CODAT. It is designed to measure different kinds of problems people experience in their lives. On the answer sheet, you'll notice that 5 stands for most of the time, and 1 for rarely. Read each statement and circle whichever of the five responses describes you best for each statement. Notice that responses 2, 3, and 4, also have descriptive labels. Please be sure to respond to all 25 items, even if it is difficult to do so. Circle the most appropriate response.

Age _____

Sex: _____ Male _____ Female Race _____

Religion: _____ Practicing _____ Non-Practicing _____

Marital Status: _____Single _____Married _____Separated

_____Divorced _____Widowed

Number of Children _____ Level of Education _____

Occupation: _____ _____

Presently Employed: _____Yes _____No

Any Previous Hospitalizations for Mental Health Problems: _____

Number of Previous Hospitalizations for Mental Health Problems: _____

Reasons for Hospitalization and/or Name or Condition(s): _____

_____

Do you have, in the present or past, a problem with the use of drugs or alcohol?

_____Yes _____No

Does your spouse or significant other have, in the present or past, a problem with the use of drugs or alcohol?

_____Yes _____No

Do your parents have, in the present or past, a problem with the use of drugs or alcohol?

_____Yes _____No

	Rarely or Never 1	Occasionally 2	Often 3	Usually 4	Most of the Time 5				
1.	I feel compelled or forced to help other people solve their problems (i.e. offering unwanted advice).				1	2	3	4	5
2.	I try to control events and how other people should behave.				1	2	3	4	5
3.	I become afraid to let other people be who they are and allow events to happen naturally.				1	2	3	4	5
4.	I feel ashamed of who I am.				1	2	3	4	5
5.	I try to control events and people through helplessness, guilt, coercion, threats, advice-giving, manipulation, or domination.				1	2	3	4	5
6.	I worry about having stomach, liver, bowel or bladder problems.				1	2	3	4	5
7.	I am preoccupied with the idea that my body is failing me.				1	2	3	4	5
8.	I feel compelled or forced to help other people solve their problems (i.e. offering advice)				1	2	3	4	5
9.	I feel that my general health is poor compared with my family and friends.				1	2	3	4	5
10.	I put on a happy face when I am really sad or angry.				1	2	3	4	5
11.	I keep my feelings to myself and put up a good front.				1	2	3	4	5
12.	I feel ill and run down.				1	2	3	4	5
13.	I hide myself so that no one really knows me.				1	2	3	4	5
14.	I keep my emotions under tight control.				1	2	3	4	5
15.	When I was growing up, my family didn't talk openly about problems.				1	2	3	4	5
16.	I have stomach, bladder or bowel trouble.				1	2	3	4	5
17.	I pick on myself for everything, including the way I think, feel, look, act and behave.				1	2	3	4	5
18.	I push painful thoughts and feelings out of my awareness.				1	2	3	4	5
19.	I grew up in a family that was troubled, unfeeling, chemically dependent or overwrought with problems.				1	2	3	4	5
20.	My family expressed feelings and affection openly when I was growing up.				1	2	3	4	5
21.	I blame myself for everything too much.				1	2	3	4	5
22.	I am unhappy now about the way my family coped with problems when I was growing up.				1	2	3	4	5
23.	I am unhappy about the way my family communicated when I was growing up.				1	2	3	4	5
24.	I feel humiliated or embarrassed.				1	2	3	4	5
25.	I hate myself.				1	2	3	4	5

APPENDIX B

STANDARDIZED ADMINISTRATION INSTRUCTIONS

Note: These directions were attached to the front of the survey packets given to respondents and were also read aloud by the researcher.

1. Your participation in this investigation is voluntary. There is no penalty for opting not to participate.

2. The results of this survey are confidential. The survey does not contain any information that would identify you personally or connect your responses to you. Results will be interpreted and discussed in terms of groups, rather than you individually.

3. Please open the packet in front of you. Do not begin answering the survey until you have been instructed to do so. Your envelope should contain a blank cover sheet, a blue sheet that asks demographic information, and a green sheet containing 25 items.

4. On the blue demographic sheet please write your answers clearly and legibly.

5. Let's take a closer look at the green sheet. Please note that you are to respond to each item using a Likert scale from 1 to 5. **A response of 1 indicates that the item *rarely* or *never* applies to you. A response of 5 indicates that the item applies to you *most* of the time.**

6. Please be sure to read each question carefully and respond as accurately as possible.

7. If you are unsure about an item, please respond to the best of your ability. Circle only one answer. Please respond using whole numbers 1-5, as they are provided. For example, do not write in a response of 3.5. Also, please do not leave any items blank.

8. On the blue sheet, the blank next to religion is asking for your religious denomination if Christian. If other than Christian, please indicate your religious preference.

9. Please do not discuss the items with anyone or make verbal utterances regarding the items until everyone is finished and the surveys are collected.

10. Please use the enclosed cover sheet to cover your response sheet while you are completing the survey. This will ensure the anonymity of your responses.

11. Please place all the survey materials back into the envelope when you have finished. Place your envelope in the collection box located in the back of the room. After turning in your packet, please quietly leave the room for break. You will be called back into the room when all participants have finished.

12. Remember, participation is strictly voluntary. If you do not wish to participate in this study, please follow the return procedure described above to prevent distinguishing between students who chose to participate and those chose not to participate.

13. Please do NOT write your name or any other identifying information on your survey materials.

14. Please read the following statement: ***My completion of this survey implies voluntary consent. All information that results from the contents of this survey or its administration will be handled in a confidential manner.***

You will have as much time as you need to complete the survey. You may begin.
Thank You.

APPENDIX C

LETTERS OF PERMISSION

KENT STATE UNIVERSITY

June 14, 2005

Terri Pardee
Program Coordinator
Master of Arts in Counseling
Spring Arbor University
106 E. Main St.
Spring Arbor, MI 49283

Dear Professor Pardee:

Thank you for your inquiry about your desire to use a codependency tool to study that concept in master level counseling students. Enclosed please find a copy of the Codependency Assessment Tool that I developed with Drs. Hughes-Hammer and Zeller. Item 20 is reverse-scored. The enclosed article indicates which items belong on the various subscales. I give you permission to copy the tool and to use it with a sample of counseling students. However, I ask that you send me the results of your study so that I can compare your results with other studies that I have done on this tool.

Best wishes for success with your research.

Sincerely,

Donna S. Martsolf, PhD
Associate Professor

College of Nursing
P.O. Box 5190 • Kent, Ohio 44242-0001
Administration: 330-672-7930 • Faculty: 330-672-3686 • Fax: 330-672-2433
E-mail: nursing@kent.edu • http://www.kent.edu/nursing

Andrews University

July 12, 2005

Terri Pardee
12565 Spring Arbor
Concord, MI 49237

Dear Terri

RE: APPLICATION FOR APPROVAL OF RESEARCH INVOLVING HUMAN SUBJECTS
IRB Protocol #: 05-081 **Application Type:** Original **Dept:** Counseling Psychology
Review Category: Exempt **Action Taken:** Approved **Advisor:** Frederick Kosinski
Protocol Title: Codependency in Master's Level Counseling Students: A Cross Sectional Perspective

This letter is to advise you that the Institutional Review Board (IRB) has reviewed and approved you proposal for research. You have been given clearance to proceed with your research plans.

All changes made to the study design and/or consent form, after initiation of the project, require prior approval from the IRB before such changes can be implemented. Feel free to contact our office if you have any questions.

The duration of the present approval is for one year. If your research is going to take more than one year, you must apply for an extension of your approval in order to be authorized to continue with this project.

Some proposal and research design designs may be of such a nature that participation in the project may involve certain risks to human subjects. If your project is one of this nature and in the implementation of your project an incidence occurs which results in a research-related adverse reaction and/or physical injury, such an occurrence must be reported immediately in writing to the Institutional Review Board. Any project-related physical injury must also be reported immediately to the University physician, Dr. Loren Hamel, by calling (269) 473-2222.

We wish you success as you implement the research project as outlined in the approved protocol.

Sincerely,

Michael D Pearson (for)
Wendy H. Acevedo-Lopez,
Graduate Assistant
Institutional Review Board
Cc: Shirley Freed

Office of Scholarly Research
(269) 471-6361 Fax: (269) 471-6246 E-mail: irb@andrews.edu
Andrews University, Berrien Springs, MI 49104

SPRING ARBOR
UNIVERSITY

July 14, 2005

Terri Pardee
12565 Spring Arbor Road
Concord, MI 49237

Dear Terri,

I am happy to approve your use of human subjects (Adult Studies Students in Spring Arbor University's Master of Arts in Counseling program) in your research for the PhD through Andrews University. I understand that this study assesses (using a questionnaire) students' level of codependency and will provide SAU's MAC program with information that may lead to revision of certain features of the curriculum.

Best wishes in your research efforts and let me know if I can help further.

Sincerely,

Garnet Hauger

Garnet S. Hauger, PhD
Chair, Human Subjects-Research Approval Committee

106 E. Main St. Spring Arbor, Michigan 49283-9799
▶ Phone / 517.750.1200 ▶ Fax / 517.750.2108

REFERENCE LIST

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VITA

Curriculum Vita

Terri Lynne Pardee

Spring Arbor University
Spring Arbor, MI 49283

EDUCATION

2007	Doctor of Philosophy, Counseling Psychology Andrews University, Berrien Springs, Michigan
1991	Master of Arts, K-12 School Counseling Michigan State University, East Lansing, Michigan
1988	Teacher Certification, Secondary Spring Arbor College, Spring Arbor, Michigan
1986	Bachelor of Arts, Spring Arbor College, Spring Arbor, Michigan

LICENSE and CERTIFICATION

Licensed Professional Counselor (L.P.C.)
School Counselor (K-12)
Michigan Secondary Continuing, Psychology and Biology

EMPLOYMENT

2002 - Present	Coordinator, Master of Arts in Counseling Assistant Professor Spring Arbor University Spring Arbor, MI
2005 - 2006	Therapist Recovery Technology Jackson, MI
1992 - 2002	High School Counselor Concord High School Concord, MI
1993 - 2003	District Crisis Response Chairperson Concord Community Schools Concord, MI